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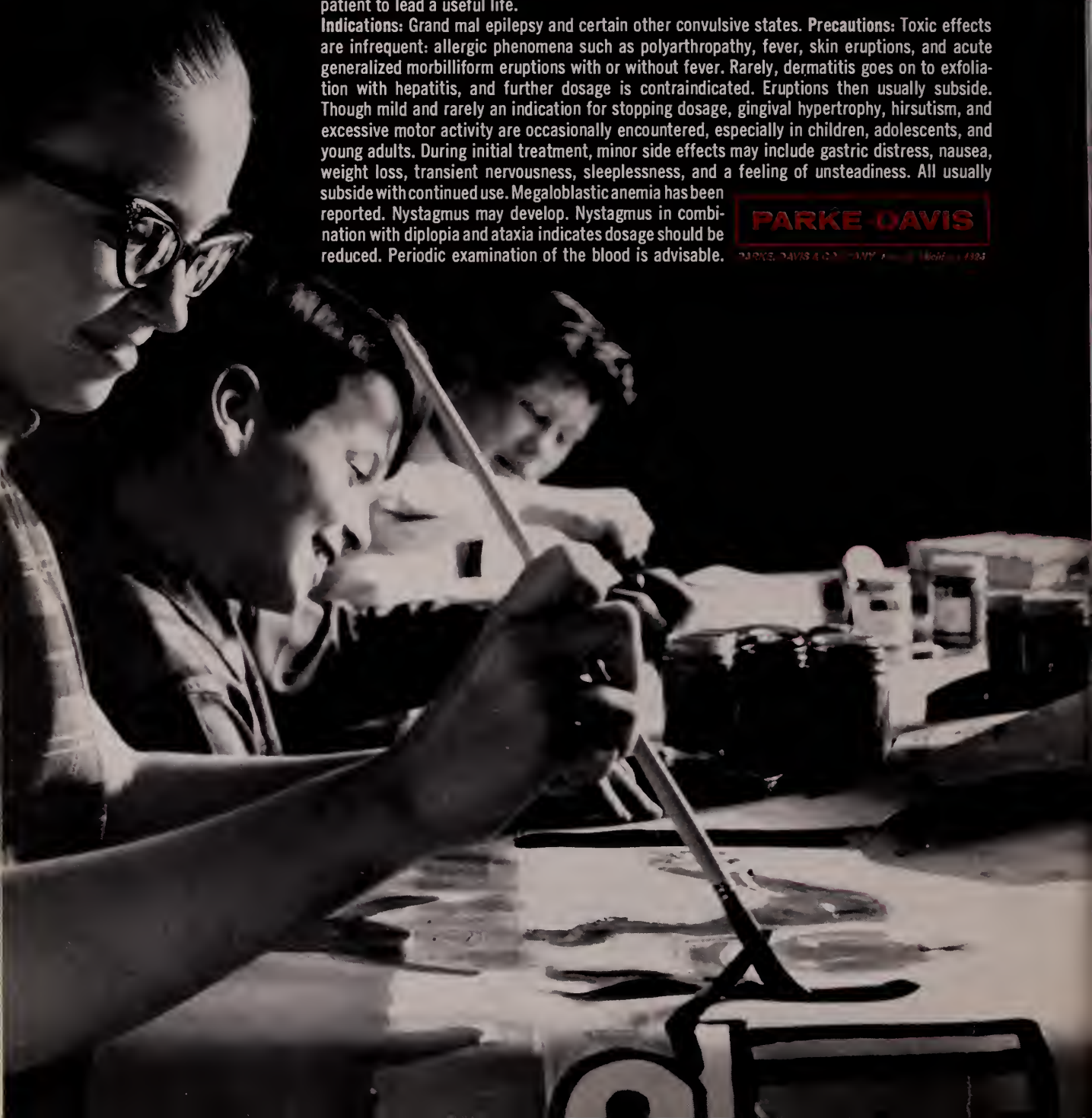
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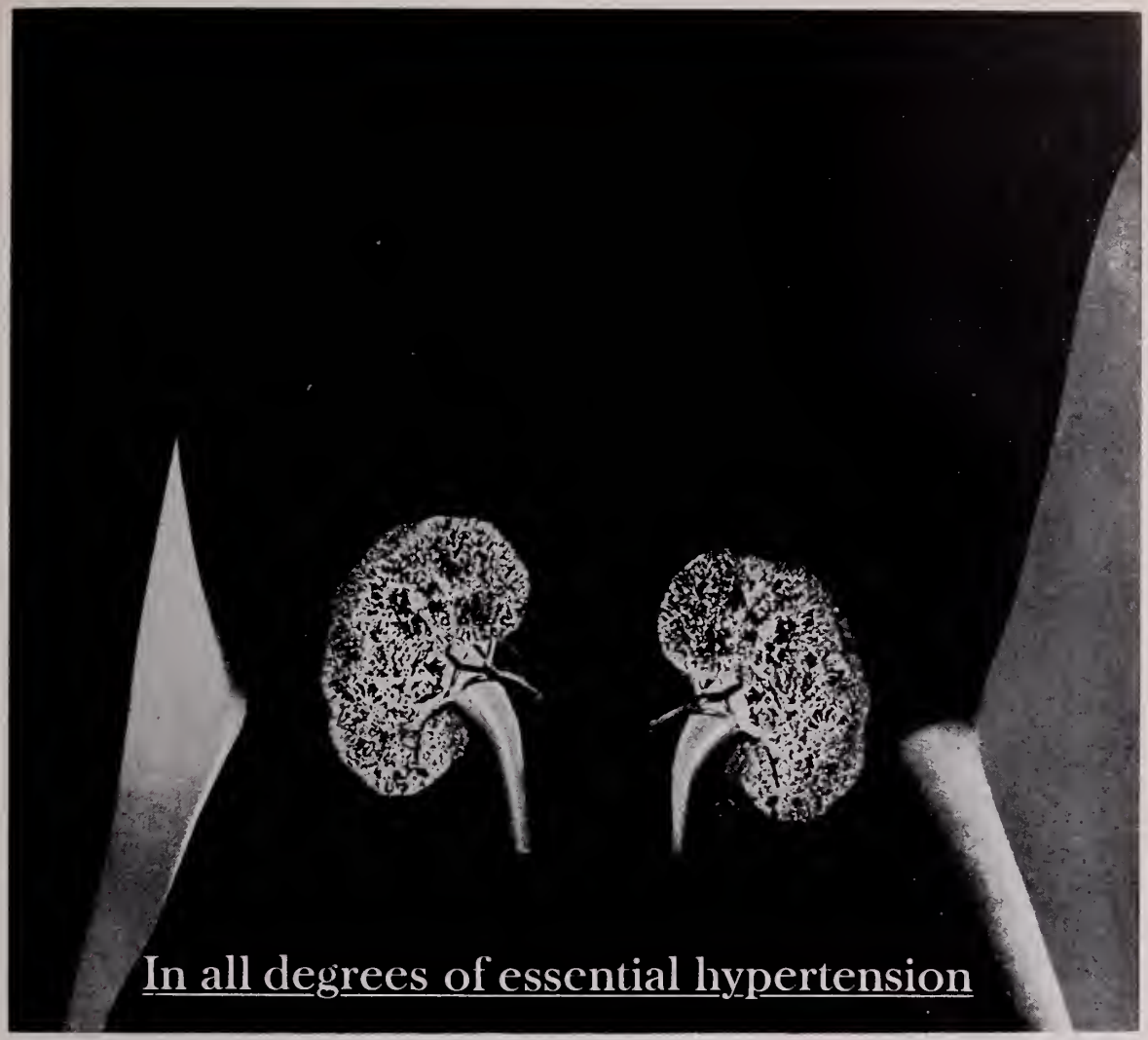
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References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

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*Schwartz, I. R.:
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The JOURNAL
of the Florida Medical Association

Volume 51, Number 1, January 1964

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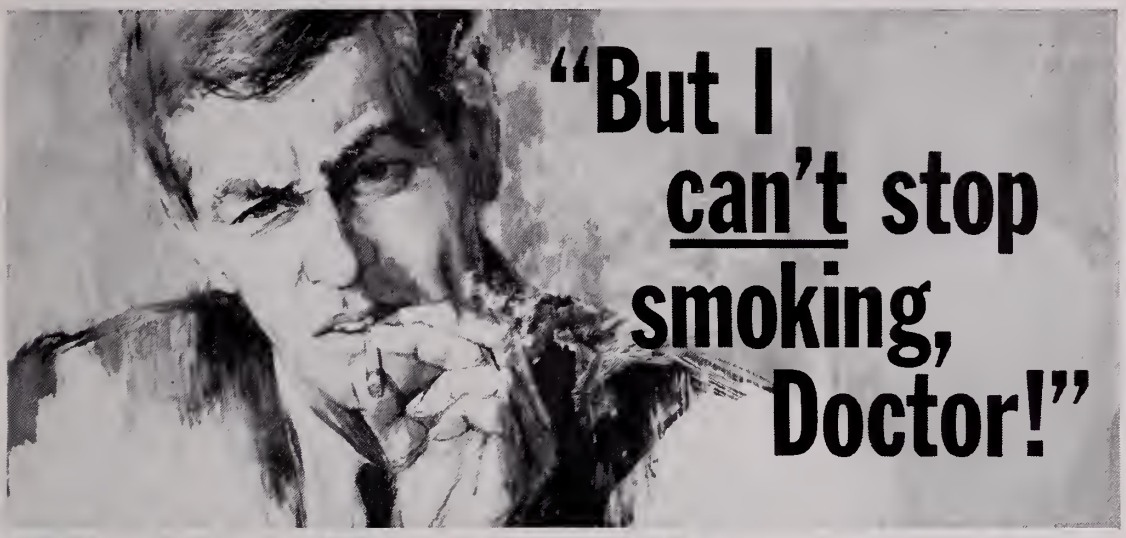
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who were the 'untreatables"?

From their inception with cortisone, to the present-day variants of the steroid molecule, the corticosteroids have presented a therapeutic paradox. The beneficial action against inflammation and allergy as well as several undesirable metabolic effects are all, apparently, the results of the same basic physiologic action.[1]

Some of these associated metabolic reactions made it risky or otherwise undesirable to treat with steroids large numbers of patients in various categories who would otherwise have benefited from such management. These "untreatables" were overweight, had cardiac disease, hypertension, or pulmonary fibrosis associated with congestive heart failure. Also in this category were those patients whose emotional symptoms were aggravated by earlier steroids.

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Side Effects. Since it may, under some circumstances, produce any of the unwanted effects common to all cortisone-like drugs, discrimination should always be exercised in administering ARISTOCORT® Triamcinolone. Any of the Cushingoid effects are possible, as are purpura, G.I. ulceration, increased intracranial pressure and subcapsular cataract. Corticosteroids generally may mask outward signs of bacterial or viral infections. Catabolic effects to watch for include muscle weakness and osteoporosis. Weight loss may occur early in treatment but is usually self-limiting.

Contraindications. While the only absolute contraindications are tuberculosis and herpes simplex, there are some relative contraindications (peptic ulcer, glomerulonephritis, myasthenia gravis, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, psychic disturbance, pregnancy, infection) to weigh against expected benefits.

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References: 1. Levine, R.: Rationale for the Use of Adrenal Steroids, Paper presented at Annual Convention, Medical Society of the State of New York, New York, May 13-17, 1963. 2. Hollander, J. L.: Clinical Use of Dexamethasone. *JAMA 172*:306 (Jan. 23) 1960. 3. Boland, E. W.: Chemically Modified Adrenocortical Steroids. *JAMA 174*:835 (Oct. 15) 1960. 4. McGavack, T. H.: The Newer Synthetic Adrenocortical Steroids in Therapy. *Nebraska Med. J. 44*:377 (Aug.) 1959. 5. Freyberg, R. H.: Berntsen, C. A., Jr., and Hellman, L.: Further Experiences with Δ1, 9 Alpha Fluoro, 16 Alpha Hydroxyhydrocortisone (Triamcinolone) in Treatment of Patients with Rheumatoid Arthritis. *Arthritis Rheum. 1*:215 (June) 1958. 6. Cahn, M. M. and Levy, E. J.: Triamcinolone in the Treatment of Dermatoses. *Amer. Practit. 10*:993 (June) 1959. 7. AMA Council on Drugs: New and Nonofficial Drugs. *JAMA 169*:255 (Jan. 17) 1959. 8. McGavack, T. H.; Kao, K.-Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: Clinical Experiences with Triamcinolone in Elderly Men. *Amer. J. Med. Sci. 236*:720 (Dec.) 1958. 9. Fernandez-Herlihy, L.: III. Use and Abuse of Corticosteroid Therapy—The Structure and Biologic Activity of the Corticosteroid Hormones and ACTH, *Med. Clin. N. Amer. 44*:509 (Mar.) 1960. 10. McGavack, T. H.: Triamcinolone: A Potent Anti-inflammatory Sodium Excreting Adrenosteroid. *Clin. Med. 6*:997 (June) 1959.

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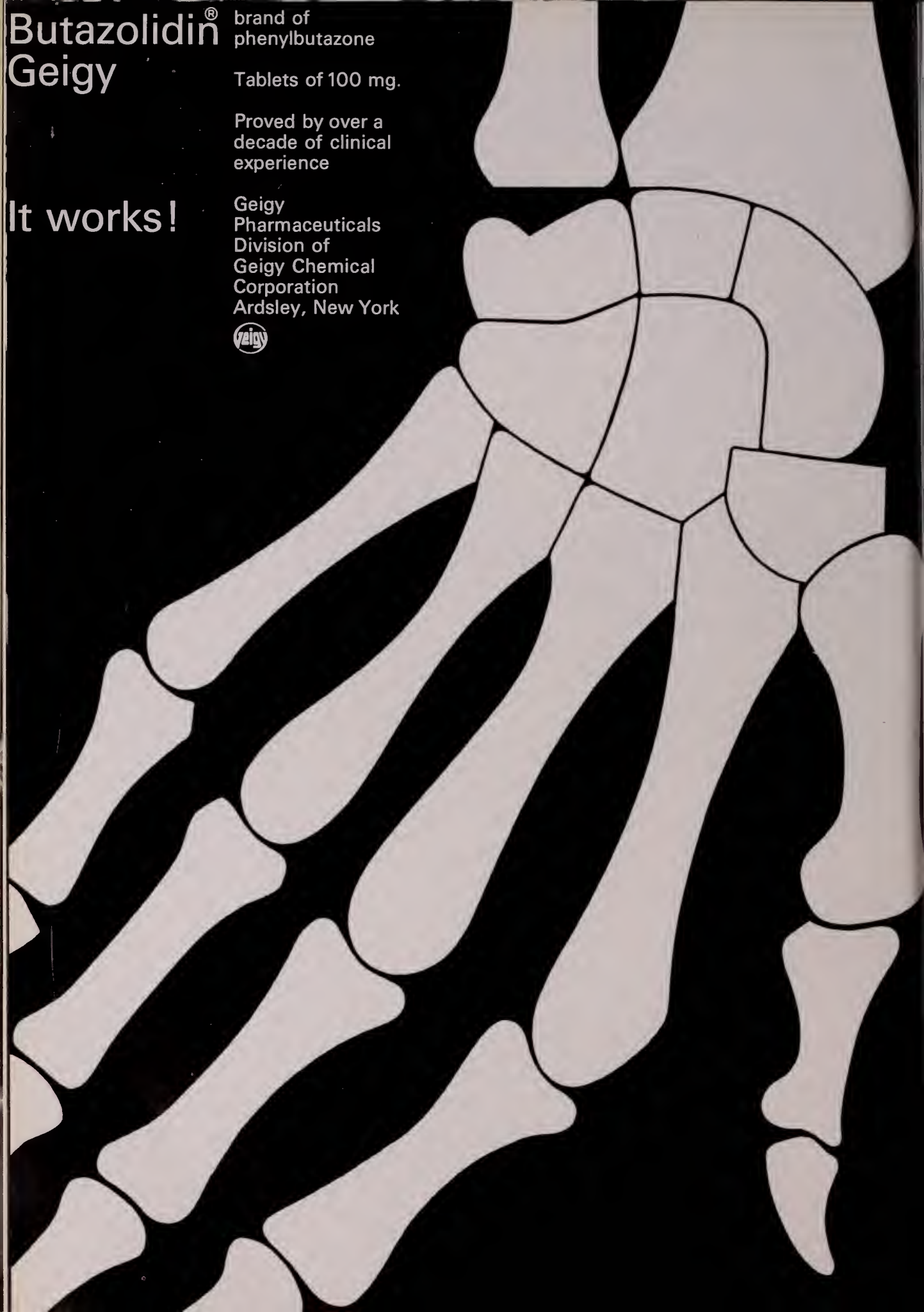
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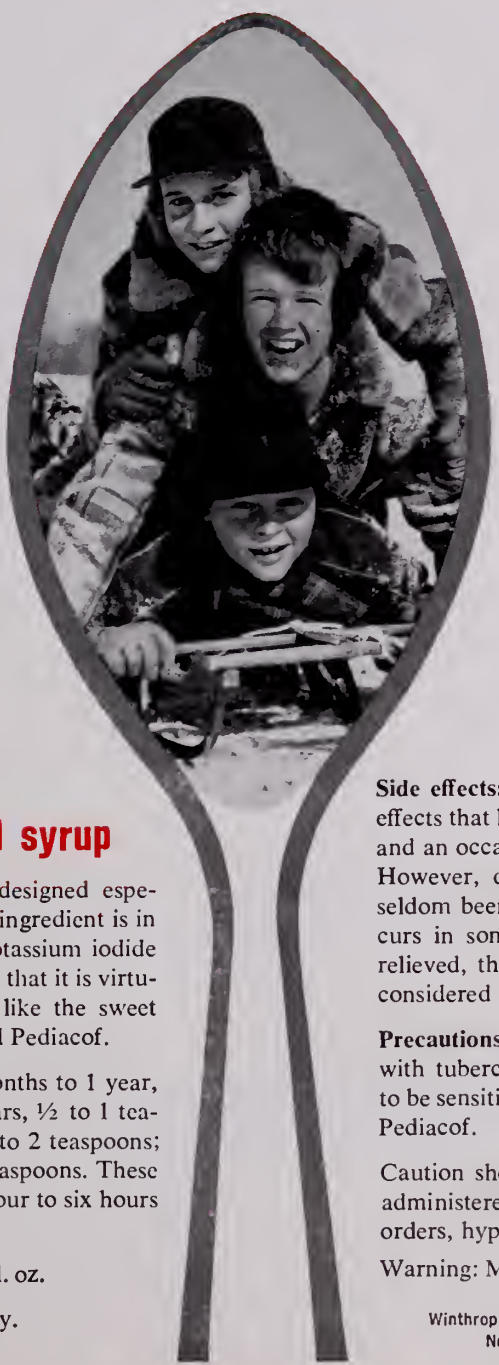
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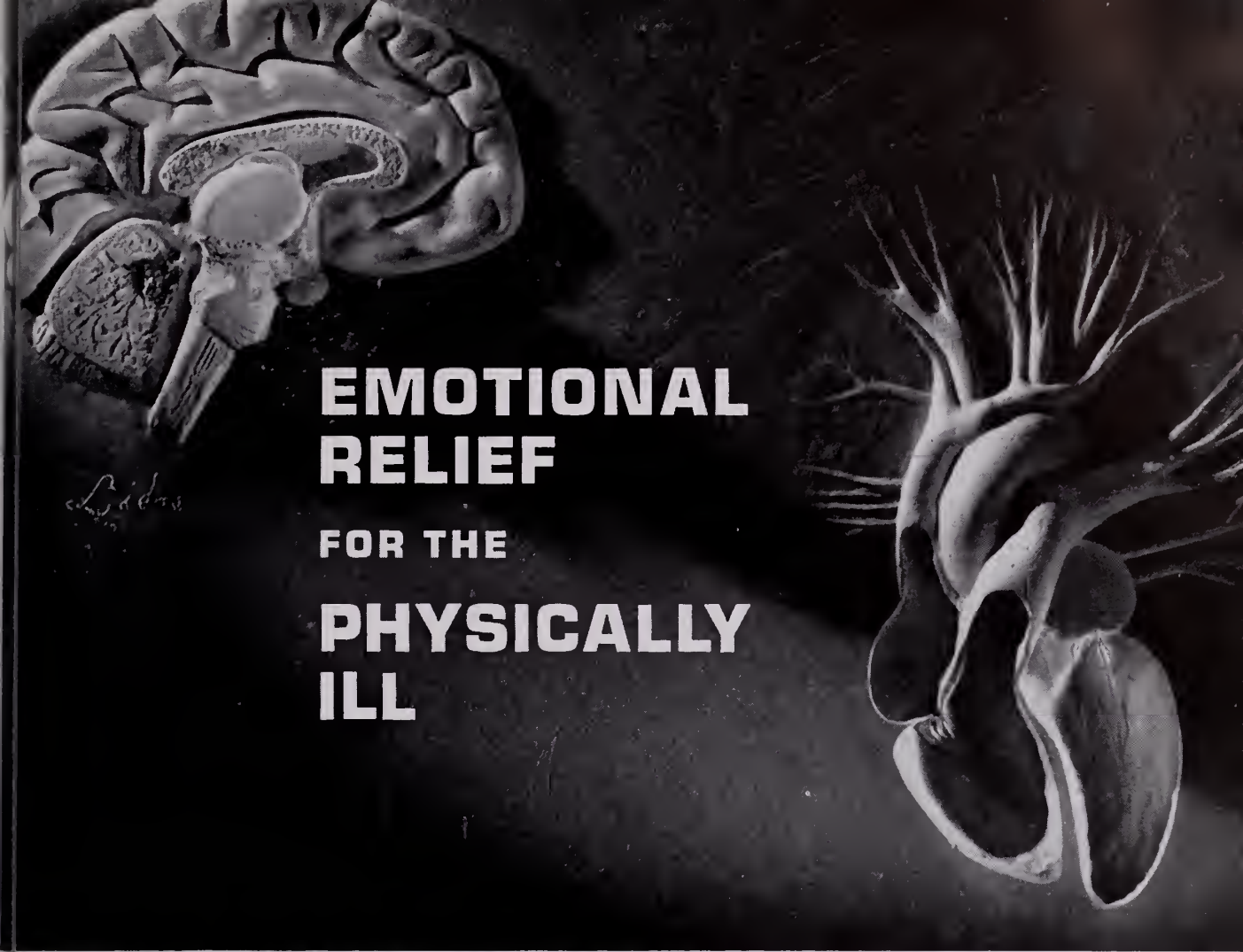
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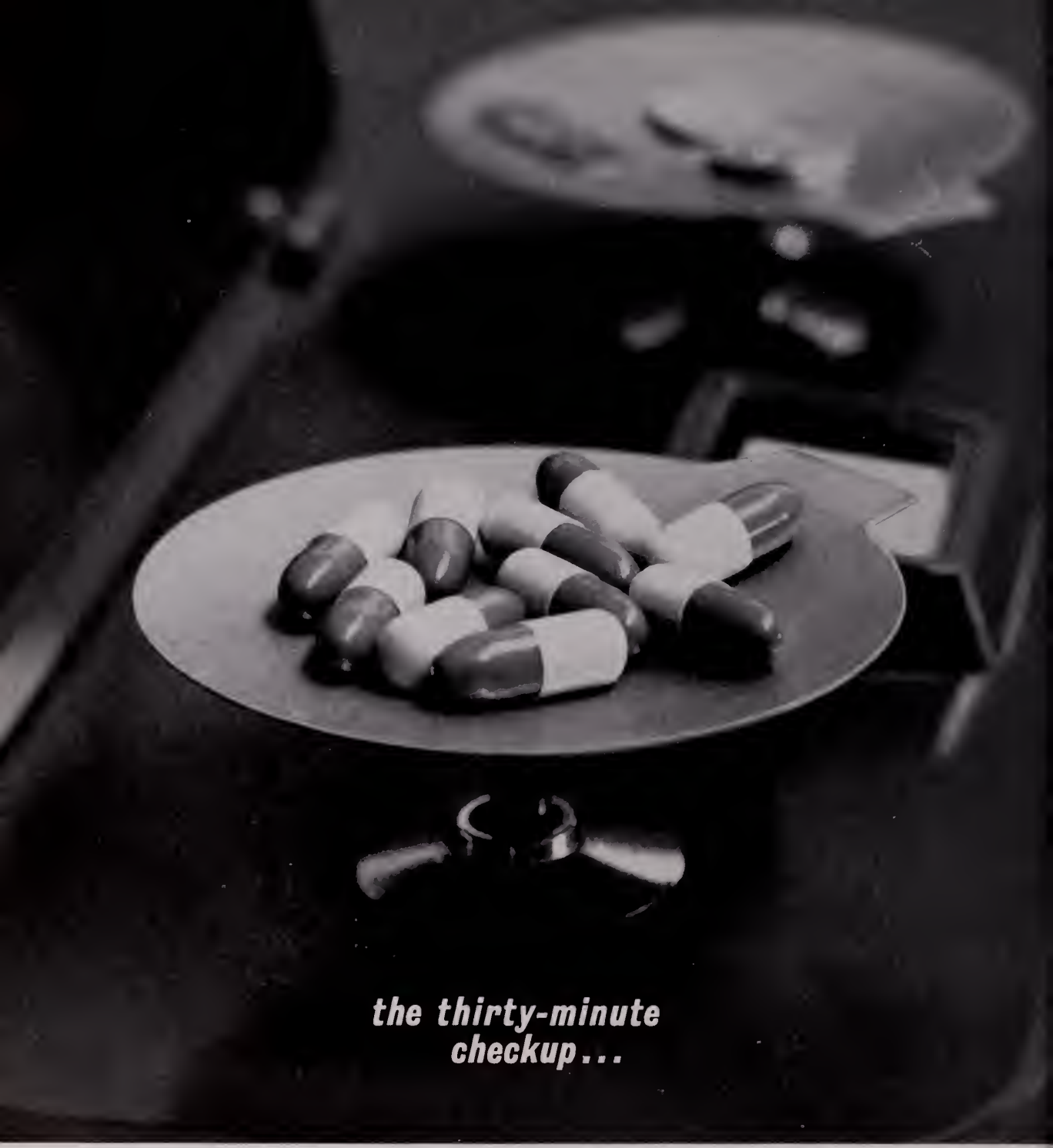
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Carotid Endarterectomy Stroke Prevention?

James D. Moody, M.D.
Orlando

During the last 10 years, carotid endarterectomy has established itself as a proved surgical procedure in the treatment of cerebral arterial insufficiency. There is no question now concerning the merit of the procedure in relieving the obstructive lesion, but additional reports seem necessary to point out the all important role of prevention that this procedure plays in the field of cerebral infarction. The present report serves to review the subject briefly with emphasis on the difference in the results of carotid endarterectomy in patients with frank established strokes and those with transient symptoms.

From an historical standpoint, atherosclerotic occlusion or stenosis of the carotid bifurcation has been recognized for the last century, the first notice of the condition being registered by Broadbent,[1] in 1875. His description was confirmed by Chiari in 1905, who described arteriosclerotic changes in the carotid bifurcation capable of producing cerebral symptoms. Hunt[2] in 1914 and Fisher[3,4] in two important papers in 1951 and 1954 directed attention to the obstructive lesions in the carotid artery from a study of pathological specimens. Fisher, in particular, made the important notation that the vessels in the brain may be entirely free of disease even though the carotid arteries are severely stenosed. In addition, he directed attention to the works of Moniz, who first introduced cerebral arteriography and depicted occlusion of the cervical portion of the internal carotid artery.

During the last 10 to 15 years, with the knowledge that such pathologic change exists in the carotid artery and with the use of arteriography, it has come to light that at least 20 to 35 per cent of cases exhibiting cerebral arterial insufficiency are due to occlusions or stenosis of the internal carotid artery at the bifurcation.[5] The surgical attack upon these localized lesions has become well established, and multiple reports in the literature attest to its effectiveness from the standpoint of restoration of blood flow.[6-8] My experience in this field concerns 45 patients with 47 operative procedures. Thirty-eight of the patients were operated on during the last three and one-half years. Endarterectomy was the primary procedure in 37 instances with two patients being subjected to operation on two occasions; thrombectomy was the definitive procedure in three other patients. Two patients with kinking of the internal carotid artery had transposition procedures while four had exploratory operations only. One other patient had a resection of a small aneurysm involving the bifurcation with acute occlusion. The shortest follow-up period is five months; the longest is three years and eight months.

Read before the Florida Medical Association, Eighty-Ninth Annual Meeting, Hollywood, May 16, 1963.

Classification

The patients in this series appeared to fall into four different classes, namely, those with completed strokes, advancing but incomplete strokes, transient strokes or symptoms, and no symptoms (table 1). Although some authors tend to classify their patients on the basis of the anatomical lesion, it appears far more important, particularly from the standpoint of understanding the results of surgery, if one categorizes these patients strictly from the standpoint of functional change rather than the type of lesion present. It is well known by all those interested in this field that many patients will be found with completely occluded internal carotid arteries with no symptoms what-

Table 1. — Classification of Patients Before Operation

Asymptomatic	3
Transient symptoms	11
Advancing and incomplete strokes	19
Completed strokes	14

soever. On the other hand, some patients are seen with incapacitating and progressive symptoms with only moderate occlusion of one internal carotid artery. Of the total number of patients, 14 presented completed strokes, 19 were in the advancing but incomplete stage, 11 had transient symptoms, and one patient had no symptoms.

From an anatomical standpoint, 13 patients had complete occlusion of the internal carotid artery with eight of these 13 presenting with frank completed strokes. Of the remainder, two patients had arteriographic evidence of kinking of the internal carotid artery, while three preoperative arteriograms were considered unsatisfactory from a diagnostic standpoint. The remaining patients, numbering 29 in all, had incomplete carotid occlusions or partial stenosis.

Diagnosis

The symptoms produced by stenosis or occlusion of the internal carotid artery are those of unilateral arterial insufficiency to the cerebrum and are usually limited to defects created by insufficient blood supply to the portion of the brain supplied by the anterior or middle cerebral arteries. The classic syndrome described many times consists of monocular visual disturbance with contralateral sensory and/or motor deficits. When the major hemisphere is involved, dysphasia or aphasia may be present.

As noted, 14 of the patients in this series were admitted to the hospital with completed strokes and with varying degrees of consciousness. Fortunately, a larger number came in with either transient symptoms or advancing but incomplete strokes. These patients are the most interesting in the entire series inasmuch as something definitive could be done before permanent neurological damage had occurred. In the 11 patients with transient symptoms, most had had intermittent episodes of numbness in one or more extremities along with an occasional bout of weakness; with involvement of the dominant hemisphere, several had some form of aphasia. There was extreme variation, of course, in the picture presented by the individual patients, the findings depending on the degree of functional occlusion present in the internal carotid circulation.



Fig. 1. — A high grade obstruction of the internal carotid artery in a 68 year old woman with early symptoms. Carotid reconstruction carried out at this stage will give over 90 per cent lasting success.

All the patients with partial occlusions had some form of bruit or murmur over the bifurcation of the internal and external carotid arteries. Many of the patients, as noted in the illustrations of the arteriograms (figs. 1-4), had evidence of bilateral disease, and auscultation would present bilateral murmurs. In patients with combined aortic valvular disease producing murmurs radiating up into the base of the neck and coexisting internal carotid artery occlusive disease, it was still possible to isolate the bruit or murmur because of the latter process in practically all the patients.

It is extremely important for the neurosurgeon to rule out any intracranial pathology which will occasionally coexist with internal carotid artery occlusive disease. In my community, the neurosurgeon almost invariably sees the stroke patient or the patient with impending stroke before any vascular surgeon is called. As a result, he has the initial opportunity of performing the arteriogram and of ruling out any intracranial lesion as a cause of the neurological impairment. Three patients in the entire series had arteriograms which were unsatisfactory as diagnostic measures, and all three patients were subsequently subjected to an exploratory operation because the clinical situation was such that carotid disease could not be ruled out. Two of these patients were shown subsequently, by open arteriography, to have normal internal carotid arteries whereas the third had a plaque at the bifurcation, but this was complicating a dissecting aneurysm of the thoracic aorta which was responsible for the original false ar-

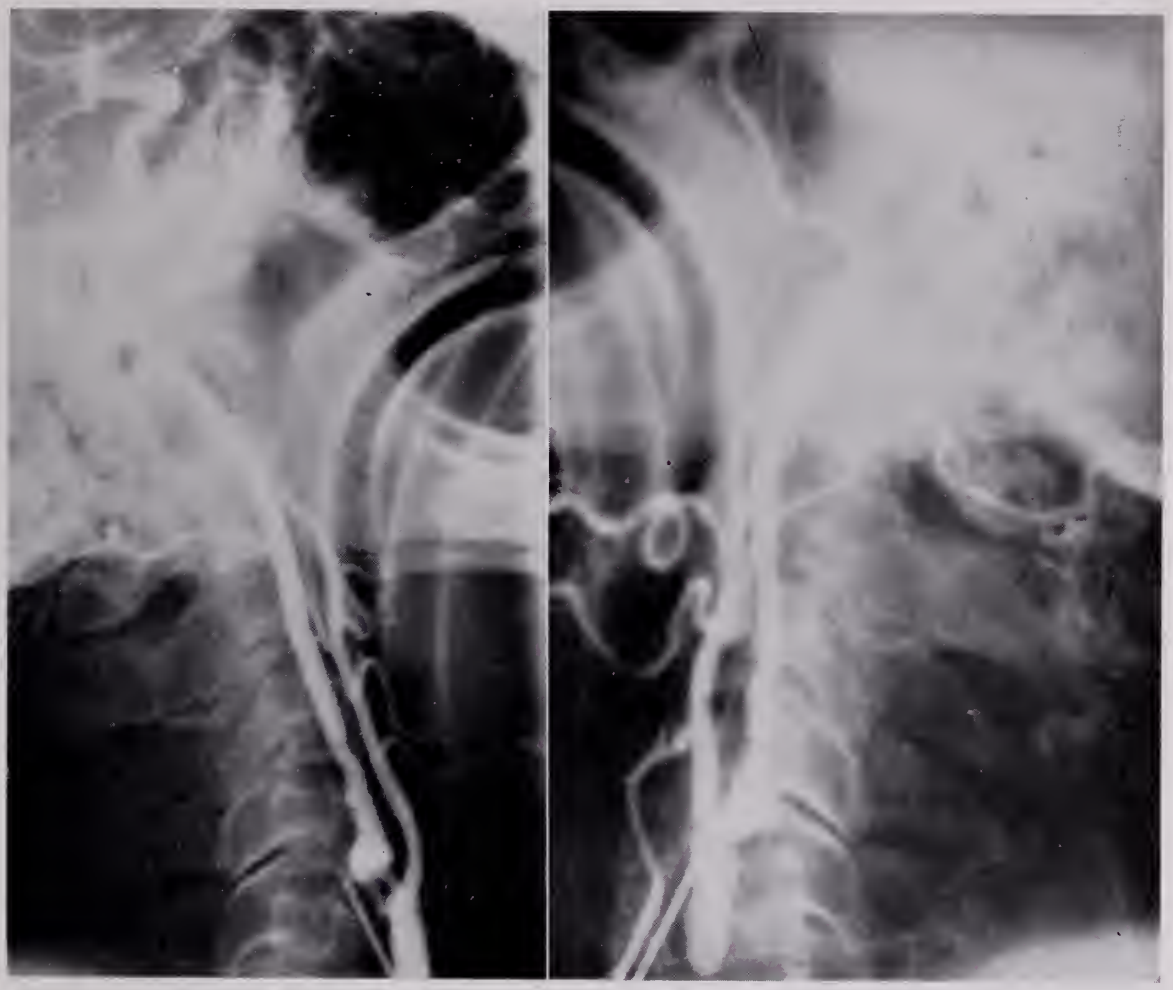


Fig. 2.—Bilateral partial occlusion of the internal carotid artery in a 65 year old dentist. Carotid endarterectomy was performed on each side with no neurological deficit.

teriogram. All the arteriograms in this series were obtained with the patient under general anesthesia, and when occlusive disease in the internal carotid artery was found and the preoperative status had been one of deterioration or progressive stroke formation, then the patient was taken immediately to the operating room and a definitive procedure carried out.

Operative Procedures

Preoperative preparation of the patient has varied with the type of functional impairment present. With the patient who has had transient symptoms only and whose arteriogram shows a partial occlusion in the internal carotid artery on one side, a period of time is set aside in the preoperative preparation to initiate adequate anticoagulant medication. In the patient with an obviously advancing and deteriorating situation, operation is performed on an emergency basis as soon as the operating room can be set up following arteriography, and the patient then placed on postoperative heparinization until consciousness is resumed and oral anticoagulant therapy instituted. Although hematomas in the operative wound have been a problem in a moderate number of these patients, it is still thought that heparin in a freshly traumatized artery is essential during the immediate postoperative phase to prevent thrombosis, and it has been thought that the protection afforded by the drug offsets the added morbidity.

Carotid endarterectomy was the operative procedure in 37 of the patients; this involved the terminal portion of the common carotid artery, the first portion of the external carotid artery and in general the first centimeter of the internal carotid artery. An external shunt utilizing two large bore needles between the proximal common carot-

id artery and the distal internal carotid artery was believed necessary in 24 instances. Some patients will have sufficient cross-filling from the opposite side to obviate the need for an external shunt, but at any time it is thought that additional blood flow will benefit the patient during the period of complete occlusion of the internal carotid artery, then the shunt is used. The insertion of the shunt and taking it down with repair of the needle holes lengthens the operative procedure, but the protection afforded by the shunt is considered essential. Some operative clinics use local anesthesia with trial occlusion of the carotid artery to preclude use of the shunt. None of the patients in this series had patch grafts, although their use has been reported in considerable detail by other surgeons. An average time of nine minutes was used in removing the obstructing material and closing the arteriotomy.

Three patients in the series were subjected to thrombectomy of the internal carotid artery. In one, fibrinolysin was injected into the distal internal carotid artery after demonstrating that the occlusion was occurring in the upper portion of the internal carotid artery, and prompt restoration of blood flow resulted from the action of the fibrinolysin. An arteriogram, 16 months later, revealed continued patency of the internal carotid artery. In one other patient in whom a thrombectomy was performed, fibrinolysin produced a moderate response in the removal of the distal thrombus in the uppermost portions of the internal carotid artery.

Two patients had symptoms which were believed to be secondary to acute angulation of the internal carotid artery. In both of these patients treatment consisted of transposition of the internal carotid artery out of the carotid sheath and on top of the sternocleidomastoid muscle. Resection of an aneurysm of the bifurcation was performed on a single patient with reanastomosis of the distal internal carotid artery to the external carotid artery. In four other patients an exploratory operation only was performed, primarily to clarify unreliable preoperative arteriograms.

Results

As many authors have noted, it is difficult to analyze the results of carotid surgery.[9] If it were a mere matter of determining the success in reopening a stenotic or occluded artery, then the situation would be extremely simple. For example, in this series of cases there were 13 patients with complete arterial obstructive lesions in eight of whom reopening of the arterial circulation to the brain occurred whereas in the remaining five, arterial patency could not be regained, or only partially so. In contrast, in 29 instances of incomplete occlusion of the internal carotid artery, 27, or 93 per cent, could be opened completely, while two, or 7 per cent, were only partially reopened. One would fall far short of the goal, however, if he were to tabulate the results of carotid artery surgery on such a basis. The functional improvement or lack of improvement should be the final testing ground for any surgical procedure, and such an analysis must be presented particularly when dealing with brain function to estimate the effectiveness of a surgical procedure such as carotid endarterectomy.

Table 2. — Results of Carotid Artery Operation

Preoperative Status	Improved	No Change	Worse or Dead
Asymptomatic	3		
Transient symptoms	10	1	
Incomplete strokes	10	5	2
Completed strokes	1	5	6

Total 43, four patients deleted

It would appear best from a functional standpoint to attempt to classify the results according to the stage in which the patient was received. In each group, of course, there are a number of patients who should be deleted from the final figure, either because of incorrect preoperative arteriograms or because of the findings noted at operation and the lack of a definitive surgical procedure. In the asymptomatic and transient symptom group combined (table 2), a total of 14 operative procedures were performed on 12 patients. Only one patient showed no change following the operation and she had an extensive block of the distal internal carotid artery which could not be reopened. This patient maintained the same level of symptoms postoperatively and died some three years later of carcinoma of the liver. The remaining 13 operative procedures all gave excellent results with no neurological deficits following the procedure and with complete relief of the preoperative symptoms. One of the patients in this group was advised to have the opposite side operated on at a later date because of bilateral stenotic lesions and symptoms resulting from the opposite side.

The third group of patients, those with progressive symptoms, numbering 19 in all, included two patients who can be deleted from the final fig-

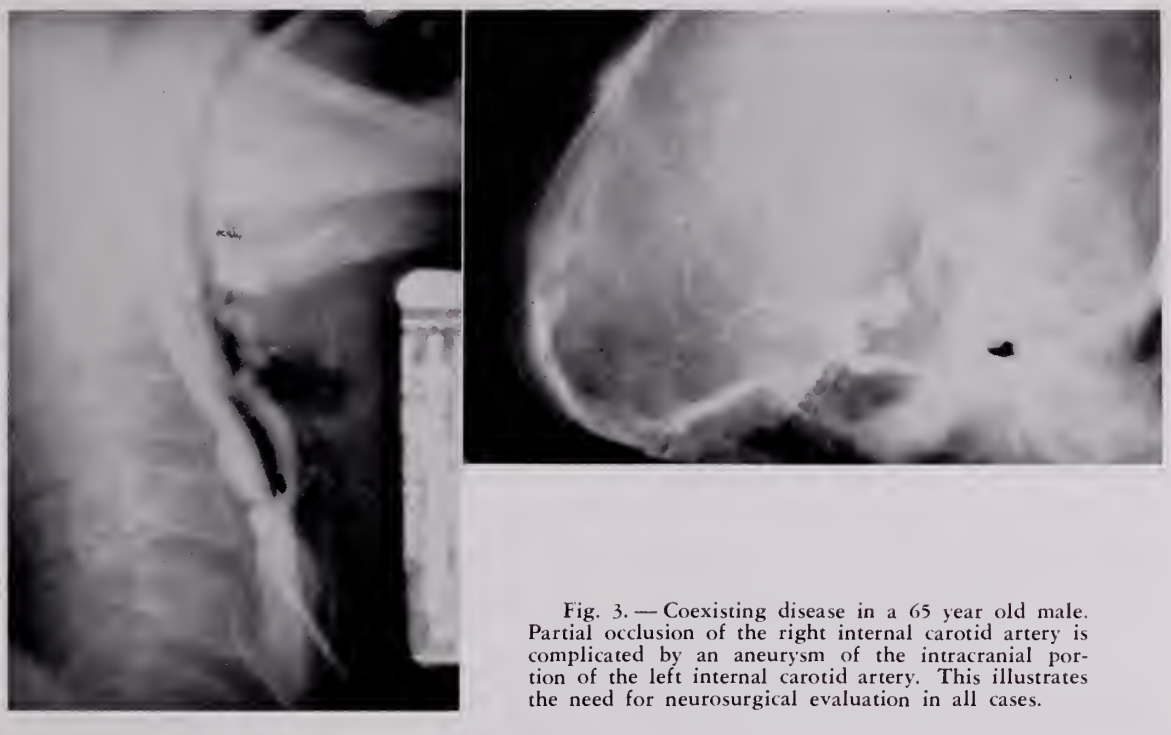


Fig. 3. — Coexisting disease in a 65 year old male. Partial occlusion of the right internal carotid artery is complicated by an aneurysm of the intracranial portion of the left internal carotid artery. This illustrates the need for neurosurgical evaluation in all cases.

ure. The first had only an exploration with the findings of congenital absence of the internal carotid artery; this patient's symptoms showed no change following the operation. In the other patient, the diagnosis was incorrect, and although a plaque was observed at the carotid bifurcation and a localized endarterectomy was performed, he died shortly after the operation because of a dissecting aneurysm of the thoracic aorta which was the original lesion causing the sudden cerebral symptoms. Of the remaining 17 patients, 10 could definitely be considered cured by the operative procedure of carotid endarterectomy. These patients remained completely asymptomatic following the operation although two died later of unrelated causes. The longest follow-up in this group is three and one-half years. One patient was made worse by the operative procedure, chiefly because of technical difficulties with the endarterectomy and with clotting occurring in the shunt at the end of the procedure. His weakness and sensory deficit were aggravated, but he has made a satisfactory recovery with the usual response noted in so many stroke patients of gradual return of function. This patient had bilateral disease with practically complete occlusion of the contralateral internal carotid artery.



Fig. 4. — An excellent example of an early thrombus distal to a high grade internal carotid artery obstruction, producing acute cerebral insufficiency. Immediate surgical correction in this 46 year old man completely prevented the impending stroke.

The remaining six patients in this group are in a particular group by themselves; no change whatsoever of benefit or aggravation was noted following the surgical procedure. Three of the patients have continued to have minor episodes of numbness in an extremity, difficulty with speech and occasional visual disturbance. Two other patients have died of progressive cerebral disease, whereas the sixth one died shortly after the operation of diffuse cerebral sclerosis and obvious early cerebral damage probably made worse by the operative procedure. It is believed that this group of six patients present combined disease of the intracerebral vessels of a diffuse atherosclerotic nature along with the disease of the internal carotid artery. It is impossible, even on going back over the arteriograms of these patients, to pick them out satisfactorily in contrast to the others who have had no further symptoms of any kind.

The patients with completed strokes showed the poorest results, as one might anticipate. Of the 14 patients in this group, two had an exploratory operation only, with the finding of a high block in the internal carotid artery, and recovery was uneventful with no significant change. One patient in the entire group improved as a result of the surgical procedure; in this instance thrombosis of the upper portion of the internal carotid artery was present. Prompt resolution of the thrombus due to the action of fibrinolysin in the internal carotid artery resulted in a surprising and complete return of function in this patient.

Of the remaining 11 patients, five showed no significant change effected by the operation, although all recovered and made the usual satisfactory progress noted in stroke rehabilitation. It is noteworthy that in four of these five patients, the arterial obstructions could be completely reopened. Practically all of these patients were admitted with complete hemiplegia, some in a conscious state and some in a coma. Four of these patients are still living with varying degrees of recovery, whereas one died of progressive brain damage one year later. Six other patients remaining in the group have died in the postoperative phase, one only six hours postoperatively of questionable cause. No neurological deficit was apparent at the time of death, and although an autopsy was performed, no specific cause of death could be ascertained. The remaining five patients all died of progressive brain damage either early or late following surgical therapy. In this group, four of the arterial obstructions were reopened, whereas two remained the same.

In summary, the results of carotid endarterectomy are directly related to the stage of the disease process. If the carotid artery occlusive lesion is still incomplete and the patient has only transient symptoms, surgical correction will be complete and lasting in over 90 per cent of patients. Once the cerebral arterial insufficiency becomes critical and symptoms become progressive in terms of hours, lasting surgical success will drop to approximately 60 per cent. When the stroke has become completed, there is less than a 10 per cent chance of an operation benefiting the patient.

Comments

It is readily apparent that a substantial number of patients with cerebral impairment have as an underlying basis carotid atherosclerotic occluding lesions. It is also readily apparent that carotid endarterectomy offers an extremely satisfactory method of restoration of blood flow at minimal risk to the patient. It would thus behoove all physicians to attempt to improve the situation by shortening the time of diagnosis and obviating the delay in getting the proper patient to the ultimate surgical relief. The diagnosis is not overly difficult and simply needs a good element of suspicion when one first examines the patient. Detection of carotid bifurcation murmurs or bruits does not require an experienced ear, and the coupling of such a murmur with transient episodes of numbness or weakness in the contralateral extremity should serve to alert any physician to the probability that a potentially dangerous lesion is in the making. There is no argument whatsoever as to the absolute need of expediting a diagnosis in patients with strokes which are rapidly developing, inasmuch as devitalized brain tissue will not tolerate such a state for a long period of time. Although some authors state that procedures can be carried out with fully established strokes of at least 48 hours, it has not been my experience that they result in any degree of improvement. It is my definite impression that patients with complete obstructive lesions in the internal carotid artery should be operated on within the first few hours, or not at all.

Numerous reports throughout the medical literature attest to the need of early diagnosis of this condition. In contrast to the lower extremity, where atherosclerotic occlusions will produce only discomfort and partial disability on the part of

the patient, the same lesion in the internal carotid artery can be catastrophic to the patient who is a functional part of society. Rob,[10] for example, reported that 50 per cent of his patients with a completed stroke suffered from transient prodromal attacks. Other authors reported that some 50 to 80 per cent of patients with episodes of neurological dysfunction of a transient nature eventually suffer a stroke, many within a year. It would thus be unwise to allow a group of patients who are having transient symptoms or who are on the verge of an incomplete stroke to progress to completed strokes if medical therapy is available to prevent this outcome. The results in the patient with transient symptoms or incomplete strokes are obviously so good as compared with the extremely poor results and high mortality with the completed strokes that it leaves little to be decided as to the necessity for promptness in early diagnosis.

The type of surgical procedure, the variations in diagnosis, the different forms of anesthesia, and the medical aids of anticoagulant therapy have not been discussed in all of the variations possible in this particular report. It seems best in any surgical endeavor of this type to use the procedure which will produce the most constant result and with the least degree of risk. The one factor, however, that remains the same in all clinics is that for any improved results, diagnosis must be made before the strokes are completed, and patients should have the benefit of operation at an early date.

Conclusion

Approximately one half of all patients treated for carotid artery occlusive disease can be improved dramatically by carotid endarterectomy.

Once a stroke is completed, there is less than a 10 per cent chance of immediate functional improvement by surgical measures.

In the rapidly developing stroke, the success of surgical relief is in direct proportion to the time used in arriving at a diagnosis, measured in terms of hours.

Carotid endarterectomy is an effective form of preventive surgical therapy if utilized at the proper time.

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Erythroblastosis Fetalis, Hydrops Type, Due to Maternal Sensitization to c

Case Presentation with Autopsy Findings

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BRADENTON

In the case described a less common but no longer rare cause of isoimmunization in the mother, namely c, and resulting erythroblastosis fetalis are illustrated.[1-4] The case also suggests that presently acceptable routine techniques of smaller hospitals not only fail to detect this and similar factors when screening donor blood for transfusion into premenopausal women, but also will not uncover the sensitized D positive pregnant woman.

Report of Case

A 33 year old, white woman, gravida VI, para IV, abortus I, was admitted to the hospital in her eighth month of pregnancy because of dyspnea on exertion, three to four pillow orthopnea, paroxysmal nocturnal dyspnea and ankle edema of approximately two to three weeks' duration. She was not in labor.

The significant past history revealed that the patient had had pneumonia at least nine times during childhood, once requiring thoracentesis on the right side for empyema. In 1955, when she was 26 years of age, the lower lobe of the right lung was removed because of symptomatic bronchiectasis. At that time she had three whole blood transfusions.

Her pregnancy history was as follows: In 1950 she delivered spontaneously a full term 4 pound, 12 ounce female infant, following two days of heavy vaginal bleeding. The hemorrhage was treated with two whole blood transfusions. The infant died after 21 months of continuous convulsions, said to be due to brain hemorrhages from birth trauma. Her second pregnancy was first manifest by vaginal bleeding several weeks after the lobectomy in 1955. Dilation and curettage were performed with a diagnosis of incomplete abortion. The third pregnancy in 1957 resulted in a full term 5 pound female infant. This child is living and well. In 1958 she delivered a full term 4 pound male infant who had respiratory difficulty at birth, but is living and well. In 1961 another full term pregnancy resulted in delivery of a 6 pound female infant who died after 26 hours of difficult breathing. The diagnosis at autopsy was pulmonary hyaline membrane disease.

Physical examination on admission showed she was dyspneic and wheezing at rest. The blood pressure was 140/85 mm. Hg and the pulse rate 80 per minute and regular. The veins of the neck were not distended. The heart was not enlarged, and no murmurs were heard. Rales were present over both lungs. The liver was tender but not enlarged. Fetal heart tones were 140 per minute, and the baby was in vertex presentation. Ankle edema was 3 plus.

Laboratory tests revealed the following: Hemoglobin 9.0 Gm., red blood cells 3.5 million per cubic centimeter, hematocrit level 32 per cent, and white blood cells 7,900 per cubic centimeter, with segmented forms 73 per cent, juvenile forms 2 per cent, basophils 5 per cent, lymphocytes 17 per cent, monocytes 1 per cent and eosinophils 2 per cent. The platelets were normal in number and morphological. The blood urea nitrogen was 13.5 mg. per



Fig. 1.—The hydropic newborn; there is marked edema of the face, neck, trunk, scrotum and dorsum of the hands. The abdomen is distended with ascites.



Fig. 2.—Placental cotyledons are bulging and enlarged, but not engorged.

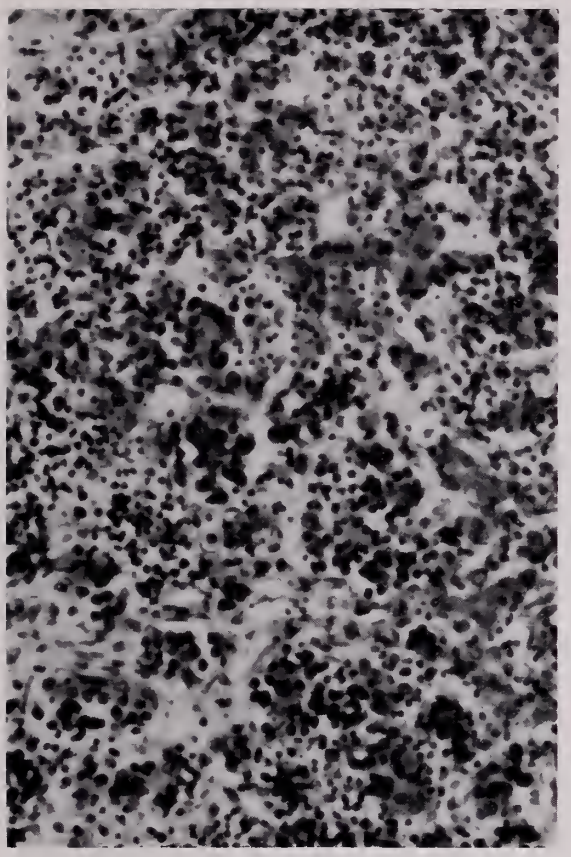


Fig. 3.—Liver. The severe erythropoiesis obscures the liver architecture. Sinusoids are congested with nucleated red blood cells (hematoxylin-eosin, x 100).

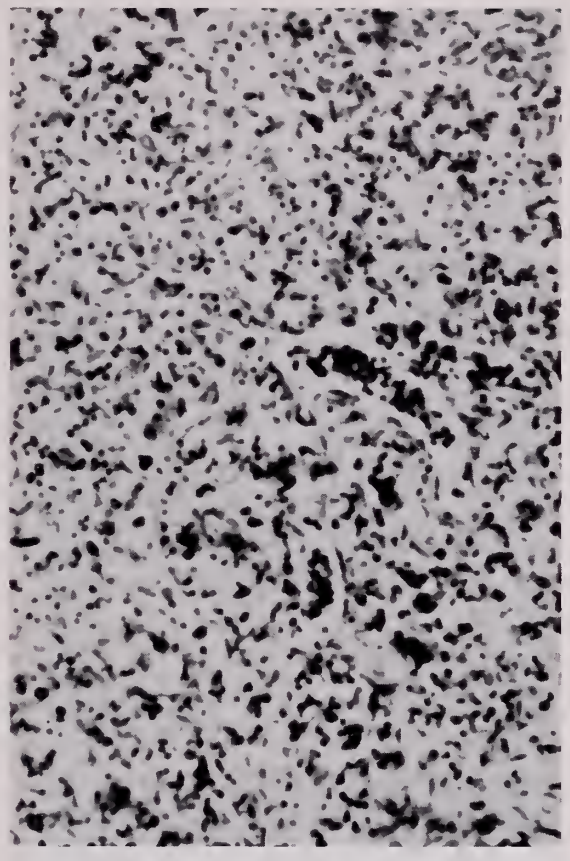


Fig. 4.—Spleen. Marked erythropoiesis congests sinusoids and small blood vessels with nucleated red blood cells (hematoxylin-eosin, x 100).

cent and the fibrinogen 304 mg. per cent (control 271 mg. per cent); the chloride was 103 mEq/L, potassium 4.4 mEq/L, and sodium 152 mEq/L. The blood type was A, D positive. An x-ray of the chest showed bilateral basilar interstitial pneumonitis, and an electrocardiogram showed a right ventricular strain pattern.

On the evening of admission uterine contractions began, and approximately six hours later, following a short episode of profuse vaginal bleeding, the patient spontaneously delivered, without anesthesia, an edematous male infant. The baby gave intermittent gasps for 15 minutes, and despite oxygen and suction, breathing and heart beat ceased.

The autopsy findings were those of hydrops fetalis. The infant weighed 2,200 Gm. and measured 43.5 cm. crown-rump length. There was pitting edema of the head, trunk, and extremities, including edema of the face, neck and scrotum (fig. 1). Pallor was marked, but jaundice was absent. No pleural fluid was present, but the peritoneum was distended and contained 100 cc. of clear yellow fluid. The subcutaneous tissues were very wet. The lungs were meaty and airless and they sank in water. The liver was enlarged and weighed 140 Gm. It was a deep, dark red and firm on cut surface. The spleen was enlarged and weighed 25 Gm. It was firm and deep red. The bone marrow was red. The other organs were grossly not remarkable.

The placenta was intact, uniformly enlarged and weighed 1,100 Gm. The cotyledons were bulging, spongy and pink (fig. 2). The fetal membranes were transparent, glistening and not discolored. The umbilical cord inserted centrally, and showed three vessels on cut surface.

The miscroscopic sections confirmed the gross impression. There was marked erythropoiesis in the liver and spleen (figs. 3 and 4). Foci of erythropoiesis were also found in the pancreas, adrenals and kidneys. Cross sections of blood vessels showed innumerable nucleated red blood cells in the lumina. The vertebral bone marrow showed activity in all series but no obvious hyperplasia (fig. 5). The sections of placenta showed edematous villi

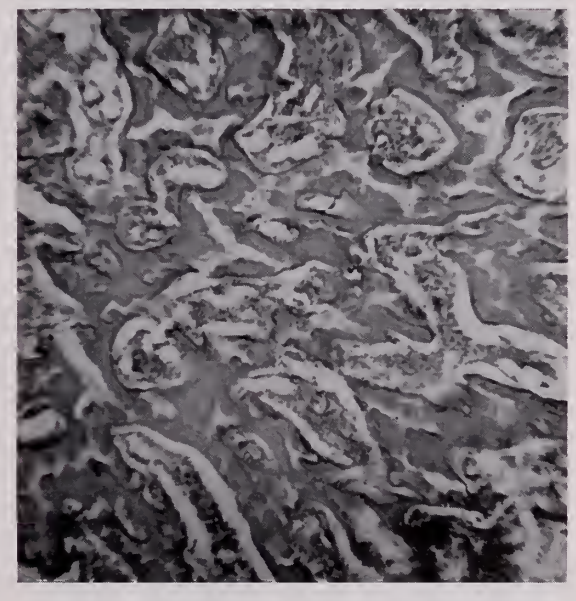


Fig. 5.—Vertebral bone marrow shows no particular abnormality (hematoxylin-eosin, x 35).

with persistence of Langhans' cells (fig. 6). Blood vessels were inconspicuous. Occasional histiocytes resembling Hofbauer cells were seen.

Umbilical cord blood taken a few minutes after the baby's death showed a hemoglobin level of 9.4 Gm. A Wright's stain smear showed the anemia of macrocytic type with approximately 25 per cent nucleated red blood cells in all stages of maturation (fig. 7).

Since the autopsy findings were those of erythroblastosis fetalis, hydrops type, three tests were performed to confirm this diagnosis and elucidate the immune factors. The direct antiglobulin test on the baby's red blood cells, using the method of Coombs, showed agglutination. The indirect antiglobulin test on the mother's serum, using O, D positive red blood cells, showed agglutination in a 1:128 dilution. The indirect antiglobulin test using the mother's serum and baby's red blood cells showed agglutination. These tests confirmed the diagnosis of erythroblastosis fetalis by showing the presence of a gamma globulin antibody in the mother's serum which was attached to and could agglutinate the baby's red blood cells in vitro.

Using commercial antisera and the suggested techniques* the phenotypes of the mother, baby, father and two living children were the following:

	Age	ABO	C	D	E	e	c	Kidd (Jk^a)	Lewis (Le^a)	Kell (K)	Duffy (Fy^a)
Mother	31	A	+	+	+	+	—	+	—	—	—
Baby		A	+	+	+	+	+	+	—	—	—
Father	38	A	+	+	+	+	+	+	+	—	+
Sister	4	A	+	+	+	+	+				
Brother	3	A	+	+	+	+	+				

The only factor the baby had which the mother did not was c and therefore it was most likely responsible for the isoimmunization in this case. Final confirmation was obtained by sending a sample of the mother's serum to a commercial laboratory.* Using a panel of red blood cells with the mother's serum, by various procedures including high protein, indirect antiglobulin and bromelase, the laboratory reported an anti-c titer of 1:64.

Comment

It is a moot point whether or not the original sensitization of this mother occurred from multiple transfusions, previous pregnancies, or both.[1,5] More pertinent here is the fact that recommended procedures, which were followed in this case (1) do not include serum antibody screening in D positive pregnant woman and (2) routine procedures for processing donors and recipients for transfusion do not at present provide for the detection of factors other than ABO and D.[6]

With the high level of awareness of D as a cause of erythroblastosis fetalis and the prompt use of preventive measures, the other factors such as c may become a relatively more frequent cause of neonatal mortality. Certainly iatrogenic sensitization (blood transfusion) can be reduced by proper selection of donor blood for transfusion into premenopausal women through more complete phenotyping. To this end, panels of commercial antisera are now available and the techniques applicable to the smallest hospital laboratory. Moreover, in pregnant women who have had either previous pregnancies or blood transfusions, the serum should probably be screened for antibodies

*Dade Reagents, Inc., Miami.

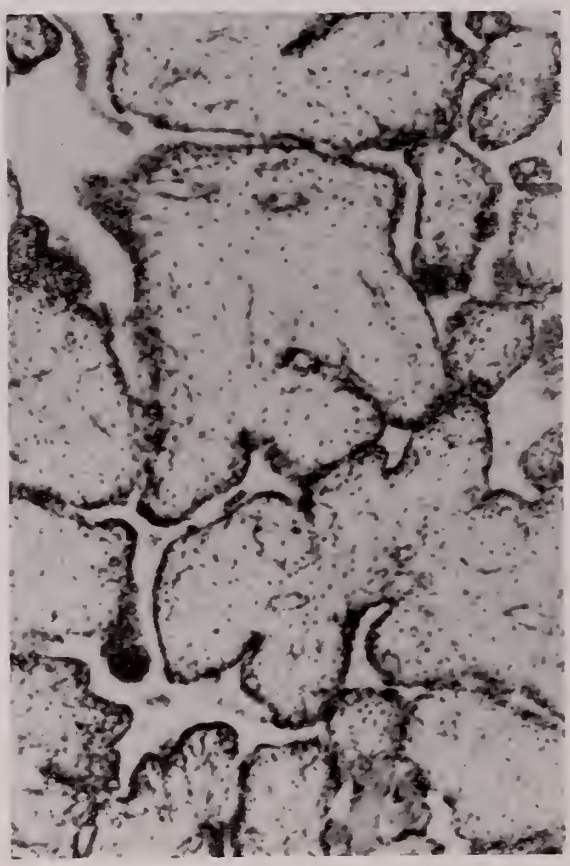


Fig. 6. — Placental villi are enlarged. The blood vessels are inconspicuous for the gestational age. Also, there is persistence of Langhans' cells (hematoxylin-eosin, x 35).

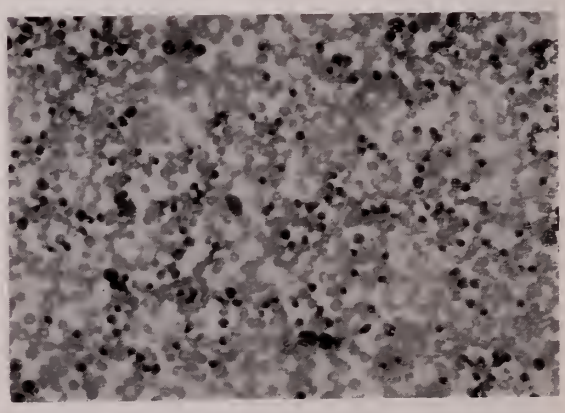


Fig. 7.—Umbilical cord blood smear. There are greatly increased numbers of nucleated red blood cells in various stages of maturation. The erythrocytes are generally macroytic (Wright's stain, x 100).

in addition to D. Screening can be done by use of pooled group O cells,** or by testing the mother's serum against the father's cells, using saline, high protein, antiglobulin and enzyme techniques. The routine application of the direct antiglobulin test to the cord blood of all newborns is another approach which has been recommended.[7]

Summary

A case of erythroblastosis fetalis, hydrops type, due to c, is presented with autopsy findings. Previous pregnancies and/or blood transfusions may have been the sensitizing events. Additions to smaller hospital laboratory techniques that will prevent iatrogenic sensitization and uncover the D positive sensitized pregnant woman are mentioned.

**Hemantigen, Knickerbocker Biologicals, Inc., New York City.

I wish to thank John G. Collins, Wilma P. Ricamore and Roberta Kirkby for valuable technical assistance.

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Small Doses of Norethindrone for Ovulation Control

A Preliminary Report

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As world overpopulation becomes a more obvious major problem, the search for a feasible method of fertility control is making considerable progress. Perhaps the most promise thus far is shown by contraceptive tablets taken in a cyclic pattern so as to inhibit ovulation. Despite handicaps of some undesirable side effects and expense, the principle has gained wide acceptance.

Several reports have shown the effectiveness of norethynodrel in two dosages: 10 mg. with 0.15 mg. of ethinyl estradiol-3-methyl ether and 5 mg. with 0.075 mg. of the estrogen.[1-4]

Also, the effectiveness and acceptability of norethindrone in ovulation control has been well documented in two recent reports.[5,6] In these studies the dosage used was 10 mg. of norethindrone, plus 0.06 mg. of mestranol. Beneficial effects other than contraceptive were lighter menstrual flow, decrease of dysmenorrhea, regularization of the cycle, and unimpairment of subsequent fertility.

Since these ovulation-inhibiting agents are composed of a progestin-estrogen mixture in a fixed ratio, it was decided to study the effect of a progestin-estrogen combination in a new and different ratio. The advantages sought in this new ratio were a decrease in undesirable side effects and a decrease in cost. A relatively larger amount of estrogen in combination with a smaller amount of progestin was used for the study which is the subject of this preliminary report.

The material used was a combination of 2 mg. of norethindrone (17α - ethinyl - 17 - hydroxy - 4-estren-3-one) with 100 gamma (0.1 mg.) of mestranol (ethinyl estradiol 3-methyl ether).*

The patients were women requesting oral medication for contraception. In a few cases, the purpose of ovulation control was to relieve dysmenorrhea or regulate the menstrual cycle. They were given vials of 20 tablets, to be taken from the fifth to the twenty-fourth day of each cycle. In a few cases where breakthrough bleeding occurred, the dosage was increased to two tablets daily for the remainder of the cycle.

*Supplied as Ortho-Novum, 2 mg., by Ortho Research Foundation, Raritan, N. J.

Table 1.—General Statistics to February 15, 1963

	Patients
Treatment begun since June 1, 1962	102
Treatment discontinued	22
Reported on at least two cycles of treatment	53
Currently active	80
Pregnancies	0

Table 2.—Reasons for Discontinuing Treatment

	Patients
Subsequent gynecological surgery	3
Unfavorable press publicity regarding contraceptive tablets	6
Did not return, or were unreliable in taking tablets	5
Side effects (nausea 5, breakthrough bleeding 1, aggravated premenstrual tension 1, amenorrhea 1)	8
Total	22

Table 3.—Statistics for Group of 53 Patients Completing at Least Two Cycles

	Patients
A. Previous Pregnancies	
None	7
One	8
Two or more	38
Total	53
B. Age Groups in years	
16-20	13
21-30	32
31-40	6
41-43	2
Total	53

C. Cycles Completed

Patients	Cycles Completed by Each Patient	Cycles Completed by Each Group	Patients Discontinuing Treatment
10	2	20	1
15	3	45	1
6	4	24	1
8	5	40	0
9	6	54	0
3	7	21	0
2	8	16	1
Totals 53		220	

D. Side Effects in 49 Patients Continuing Treatment

Nausea, slight, first cycle only	5
Breast soreness, slight, first cycle only	2
Breakthrough bleeding	3

Results

A total of 102 patients have started treatment since June 1, 1962 (table 1). Of these, 22 discontinued treatment for various reasons as shown in table 2. Eighty patients are currently taking the medication, but only 53 have reported on two to eight cycles (table 3). Most of the patients are of proved fertility, and a number had used other means of contraception without success. No pregnancies have occurred in this series. A gain in weight of several pounds was noted in a few cases. No edema and no signs of thrombophlebitic phenomena were observed.

As has been noted in other studies, other desirable effects were a tendency to lessening of menstrual flow, decrease in dysmenorrhea, and regularization of the cycles. In fact, many patients volunteered that they would like to use the medication for these beneficial effects alone.

Undesirable side effects were minimal and resulted in eight patients deciding to discontinue the medication. Nausea was noted in 10 patients. Five of these continued, with disappearance of the nausea after the first week or two. The other five discontinued the medication.

Breakthrough bleeding resulted in only one patient discontinuing the medication, in the second cycle. One patient had prolonged amenorrhea of over six weeks following the first cycle, and therefore did not continue.

No masculinizing tendency has been noted thus far. There has been no decrease in libido, and no acne or urticaria has occurred.

Summary

This is a preliminary report on a study in progress on over 80 women who are using a new combination of progestin and estrogen for suppression of ovulation. The medication consists of a tablet containing 2 mg. of norethindrone and 0.1 mg. of mestranol. This combination shows promise as an agent of increased acceptability because of lessened cost and decreased undesirable side effects.

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Practicing Pediatrics 1896-1903

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In retrospect, the striking feature of the practice of pediatrics at the turn of the century was the absence of specific treatment. In sharp contrast to current therapeutic measures, treatment in the hospitals of Boston, Paris, London and Edinburgh, where I was privileged to serve, was directed to the alleviation of symptoms and the prevention of complications. For the infectious diseases—scarlet fever, measles, rubella, varicella, vaccinia, pertussis, mumps, typhoid fever, tuberculosis, pneumonia and influenza—only symptomatic treatment was rendered at the Boston City and Children's Hospitals, the Massachusetts General Hospital and the Worcester City Hospital during my service there because no specific treatment was known.

Scarlet Fever

Scarlet fever, for example, was believed to be due to a microorganism of unknown nature. Complications were usually associated with the growth of Streptococcus pyogenes; some regarded this organism as the cause of the disease, and others thought it was a secondary invader of the mucous membranes. As a resident in the scarlet fever wards for six months, I observed that the incidence and virulence were far greater in the winter school months than in the summer vacation months. The mortality rate was appalling during January, February and March, whereas in the summer months, with the ward windows wide open day and night and the patients often carried out into the sun on the pavillion for the day, I do not recall a single death.

Pneumonia

Being self-limited, pneumonia was treated as the other infectious diseases, by hygienic methods of good nursing for comfort, preventing complications and meeting individual symptoms. In primary bronchopneumonia, the pneumococcus often was the lone offending organism, as in lobar pneumonia. In mixed infections it was frequently associated with the streptococcus, particularly if complicating measles, diphtheria and scarlet fever. Next in point of frequency were the Staphylococcus and Friedländer's bacillus.

Diphtheria

In 1897, prophylaxis for diphtheria was isolation, and in exposed cases we gave 1,000 to 2,000 units of antitoxin. In the treatment of all severe cases, including those of laryngeal stenosis, children over two years of age received an initial dose of from 1,500 to 2,000 units, which was repeated in 12 to 16 hours if there was no improvement and again in 24 hours if the course of the disease was unfavorable. In exceptionally severe cases, if seen late, the child was given as high as 3,000 units, while in mild cases more than 1,000 units was rarely required. For children under two years of age, the initial dose was 1,000 units in severe cases or those with laryngeal stenosis, to be repeated if necessary, and 600 units in mild cases. If death occurred, the antitoxin was at first believed to be the cause, not only by the laity but by many of the old time heavily bearded family doctors.

By 1903 and 1904, as resident at the Contagious Diseases (South) Department of the Boston City Hospital, I was giving antitoxin much earlier and had pushed the dosage up to as high as 100,000 units in severe laryngeal and septic cases. It was then believed that one large initial dose, given early, was much to be preferred to repeated small doses. Intubations were our choice over tracheotomies, preferably performed on arrival at the hospital. If the family doctor telephoned that the child was moribund, the intubation was performed, with the assistance of a good orderly, on the dining room table. If death occurred, the mob sometimes became uncontrollable unless the priest or the family doctor was present.

Typhoid Fever

The incidence and mortality of typhoid fever in children was low, and treatment was entirely symptomatic. Sixty years ago Eberth's bacillus was found in abundance in the intestinal discharge of affected persons. At first, diagnosis was made from the symptoms, but in March 1897 Widal's serum test, the clumping of typhoid bacilli, was published in the American Journal of the Medical Sciences and the New York Medical Journal. After the first week or 10 days of the disease the Widal reaction proved to be a great help. In the cases that came under my observation the disease was contracted from infected water, milk or food, such as oysters. In the summer vacation, a Harvard student with "walking typhoid" was em-

ployed on a farm near Holden, Mass., to milk cows. The Worcester City Hospital received eight patients from that milk route, all with very severe cases of the disease.

Syphilis

At the end of the last century, Dr. Post of Harvard taught us at the Boston Dispensary that syphilis was a communicable disease due to a specific poison. He treated this disease when the first positive symptoms appeared. The indirect treatment through the mother's milk had been given up. Mercury, considered a specific for both the hereditary and acquired types, was given by inunction, by mouth, by fumigations, by baths and hypodermically. In young infants inunctions were preferred. Ten grains of mercurial ointment, diluted with an equal amount of vaseline, was rubbed daily into the palms, soles, axillae or inner surface of the thighs, changing the place from day to day. Gray powder or the bichloride was substituted when the family was to be kept in ignorance of the treatment. With urgent symptoms, calomel was substituted for a few weeks. The iodide of potassium alone or in combination with mercury was used when tertiary lesions were present.

Mercury treatment was continued for at least a year, or longer if symptoms persisted, with short periods of intermission. If the child became anemic or suffered greatly from general malnutrition, the mercury was discontinued for the time being and cod liver oil, iron, wine and other tonics were substituted.

Malaria

In 1897, malaria was recognized as a general infectious disease caused by the presence in the blood of a specific organism known as Plasmodium or hematozoon malariae, discovered by Laveran in 1880. No one, however, had the slightest idea how this parasite entered the blood to cause extensive destruction of the red blood corpuscles, with subsequent anemia. In 1900, two years after the pioneer work done in Havana, Dr. Clifton F. Hodge, Professor of Entomology at Clark University, asked me to take charge of the field work with his students in biology in an effort to locate the breeding places of the Anopheles punctipennis and A. maculipennis in Worcester County.

The hospitals were full of patients with malaria, whose addresses we obtained along with those of hundreds of patients of private physicians. Our field work soon demonstrated that the Anopheles was usually breeding within 200 yards of the malarial victims. After much photography and laboratory work showing adult infected mosquitoes clinging to cellar rafters in the homes of malarial victims and larvae and pupae wigglers breeding nearby in slow-running grassy streams, Professor Hodge and I were ready to act. With about 60 colored slides, we started an educational campaign through women's clubs, the Board of Trade, medical societies in Worcester and Boston, newspapers, magazines, schools and churches. Drainage, filling in, and oiling the breeding places wiped out malaria in one season in Worcester County.

Treatment was symptomatic, plus quinine. For infants, we gave the bisulfate in an aqueous solution, one grain to the teaspoonful. For children from two to seven years old, we concealed the taste of quinine by mixing the aqueous solution with the syrup of sarsaparilla, orange or yerba santa. In small doses the lozenges of tannate of quinine combined with chocolate served admirably. In chronic cases, iron, arsenic and a change of climate were recommended.

Rheumatism

During the first years of the present century, rheumatism in children was believed to be manifested not alone by arthritis with acute or subacute symptoms but by a large number of other conditions regarded as forms of the disease rather than complications. Acute rheumatism was believed to be an infectious disease, probably of unknown microbic origin. Excessive acids or specific poisons were considered. Age, heredity, damp dwellings, and wet, poor hygienic surroundings, insufficient food and bad housing, spring months, and previous attacks all played a part. To avoid cardiac complications flannel underclothes, milk freely, avoidance of cold damp feet and weather, and a warm dry climate in winter and spring were urged, also bed rest during an attack if the patient was feverish.

Otherwise, the child was treated much as a young adult. In acute cases, salicylate of soda, oil of wintergreen, or salicin was given. Alkalies, such as the acetate or citrate of potassium or the bicarbonate of sodium, were used in sufficient quantity to make the urine alkaline.

Diabetes Mellitus

Fortunately, diabetes mellitus occurred rarely in children under 10 years of age. Heredity, gout, insanity, nervous diseases generally, even head

injuries and prolonged consumption of large quantities of sugar were considered possible etiologic factors. Often the polyuria, polydipsia, polyphagia and wasting were of rapid onset. Incontinence of urine and genital irritation always aroused suspicion. Diagnosis depended on examination of the urine. In the nineteenth century, when we made a diagnosis of diabetes mellitus in children, we were ready to sign the death certificate. Cases were, however, on record in which recovery was believed to have taken place. As with adults, treatment consisted of diet, stimulants, general hygienic measures, and finally, the use of drugs such as codeine, salicylate of soda and the bromide of arsenic.

Other Diseases

In pertussis, the local treatment of insufflations and inhalations of powders such as quinine and benzoic acid and internal medication with quinine, belladonna and antipyrine were of questionable value. The routine treatment of tuberculosis in children consisted of diet, quiet, fresh air, creosote and fresh emulsions of cod liver oil, with no drugs if they upset the digestion. The general treatment of leukemia was the same as that for anemia. Arsenic given in large doses for a long time had the most testimony in its favor. Iron and cod liver oil came next. Leukemia was not sharply differentiated from simple anemia with leukocytosis and from the pseudoleukemic anemia of infancy. Without x-rays, it was necessary to administer primary ether to diagnose fractures for two reasons, to relax muscles and relieve pain for a more thorough palpation and to prevent a suit for damages in case of a poor result.

The end of the nineteenth century marked the passing of the horse and buggy days and the grand old family doctor — patient and capable, considering what he had to work with.

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Nursing Education in Florida's Community Junior Colleges

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The expansion of junior colleges in the United States is one of the most important developments of the twentieth century. Six hundred and ninety-eight junior colleges are listed in the 1963 Junior College Directory. The outstanding growth of these two year institutions in Florida is due to the vision and unceasing work of many interested individuals and groups of people throughout the entire state. The Florida legislature authorized the establishment of public junior colleges for the first time in 1939 although several junior colleges had been in operation prior to that date. In 1955 the Community College Council was created to develop long range plans for the expansion of these institutions. After a thorough study of post-high school education in this and other states, the Council recommended a master plan for the orderly development of community junior colleges in Florida. Eventually, these institutions will be located in strategic areas throughout the state so that 99 per cent of Florida's high school graduates will be able to commute from home to college.

Briefly, community junior colleges offer three types of educational programs for students seeking to: (1) transfer after two years of college work to complete requirements for a baccalaureate degree; (2) prepare for employment in a specific occupation; (3) acquire more formal education in areas of special interest on either a credit or noncredit basis. Associate degree nursing programs fall into the second category.

Nursing was slow to follow many vocations in taking full advantage of the opportunities made available by the organized educational system of the country. More than a decade has elapsed however, since a new type of nursing education pro-

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gram was established in community junior colleges. In 10 years, the original eight associate degree nursing programs located in six states increased to 78 programs in 24 states. Several additional programs are scheduled to be in operation by September 1963.

While this is the story of associate degree nursing programs, there are two other types of educational programs preparing nurse practitioners. The majority of registered nurses are graduates of diploma programs sponsored by hospital schools of nursing. Colleges and universities offer programs leading to the degree of Bachelor of Science in Nursing. A physician, with the help of some of his colleagues, established the first university school of nursing in 1909.

Scientific discoveries, advances in technology, and the impact of social developments have profoundly altered curricular offerings in all educational programs. There was early recognition that nurses needed more and more knowledge to cope with the increasing complexity of nursing and the problems relating to the health and welfare of contemporary society. The needs and demands of a rapidly growing population brought about changes based not only on circumstance, but on careful planning and the purposeful implementation of these plans. Educational programs in nursing began to focus upon the kind and amount of preparation necessary to assure technical competence coupled with essential knowledge in the natural sciences, the behavioral sciences, and the humanities.

The curriculum in associate degree nursing programs is a combination of general and specialized education courses in approximately a fifty-fifty distribution. Fragmented courses are grouped into a broad core of essential nursing content. Learning experiences in the care of patients are designated as laboratory practice, with hours and credits apportioned in the same ratio as other courses in the college requiring a laboratory period. The product or graduate of the educational program is prepared to give safe and competent nursing care to patients.

It was not surprising that the junior colleges at St. Petersburg, Pensacola, and Palm Beach had started nursing education programs by 1959. Meanwhile, the junior college movement was growing and interest was mounting in associate degree nursing programs. This development had been anticipated and planned for by key people in the state.

Over the years, the W. K. Kellogg Foundation, Battle Creek, Michigan, has provided financial assistance to programs for improved health services in the public interest in various parts of the country. The scope of philanthropy embraces many projects in Medicine, Dentistry, Public Health, Hospitals, Education, and Nursing. The Foundation is currently aiding four states—Florida, California, New York, and Texas—to establish new preservice education programs in nursing leading to an associate degree. Simultaneously, universities in each state were recipients of a grant to strengthen or develop Master's degree programs designed to prepare instructors to teach nursing in community junior colleges.

The Florida Project

Specifically, the Florida Project proposed to initiate five new associate degree nursing programs. Three programs are already in operation at Manatee Junior College, Bradenton; Daytona Beach Junior College; and Dade County Junior College, Miami. Three more programs are now in the planning stage at the Junior College of Broward County, Fort Lauderdale; Central Florida Junior College, Ocala; and Gulf Coast Junior College, Panama City. It is expected that, by September 1963, nine programs in nursing education will have been established in the same number of public community junior colleges.

Another objective of the project was reached when the University of Florida developed a post-baccalaureate program designed to prepare instructors to teach in associate degree nursing programs. One graduate of this program is currently teaching at Daytona Beach Junior College. Four students are expected to complete requirements for the Master's degree this summer. Several students are enrolled for part time graduate study. The faculty of the College of Nursing has actively participated in workshops and institutes sponsored by the project. Four of these meetings were held on the campus of the University.

Consultation services is the third approach used to attain the ultimate goal of improving and expanding nursing education and nursing services. The project has provided assistance to college faculties in developing the nursing curriculum, and to nursing service personnel in hospitals for the purpose of strengthening existing programs or initiating inservice education programs. Nurses throughout the state have shown a great deal of interest in sharing ideas and exchanging instructional and other resource materials.

The Florida Project is cosponsored by the State Department of Education, Division of Community Junior Colleges, the State Board of Nursing, and the University of Florida. Many facets of this five year program were built upon work that had been started prior to 1959. The foresight and efforts of these leaders were directed toward meeting the present and future needs of the citizens of the state in education, health, and welfare. As a consequence of this planning it has been possible to: (1) establish new nursing programs in junior colleges; (2) develop a graduate program to prepare teachers of nursing; and (3) provide inservice educational opportunities for faculty and nursing service personnel. The project will terminate in 1964, but the work will continue through the junior colleges and through the State Board of Nursing.

Educational programs prepare the beginning worker. The level and scope of nursing practice cannot reflect more knowledge than the practitioner brings to the work situation. To assure a high quality of patient care it is necessary for nurses to know the "why" as well as the "how", and for them to seek continuously more educational experiences as new knowledge emerges from the rapid advances being made in medical science and technology. This aspect of continuing education is a mutual responsibility of nurses and employing agencies.

Florida's statewide coordinated approach to improve and expand nursing education and nursing services points the way to future plans and action. The goal of excellence in patient care can be accomplished by increasing the number of nurses graduated annually from educational programs combined with a sound plan to utilize effectively the services of nurses in employment situations. Progress has certainly been made.

Comment

Alice D. Hourihan, R.N,* Coral Gables: The excellent paper on "Nursing Education in Florida's Community Junior Colleges" is constructive and thought-provoking. Basically, the climate in which nursing exists today includes the social, political, economic, and cultural aspects of American life in the 1960s. Of vital importance is the way in which nursing affects and is affected by the crucial issues with which we must be concerned and their impact on patient care—better care than we have today.

These issues relate to such broad matters as the growing independence, knowledge, and therapeutic abilities of the patient himself. They are issues inherent in the interchangeability of the role of the nurse. They are issues that have to do with the evaluation of nursing education; with administrative responsibilities for patient care; with the image of nursing; with the revolution going on around us in teaching and communications; with the mixed public attitudes about government versus voluntary responsibility for vital community services.

At the present time, to synthesize these issues concretely would enhance and enrich their significance to the future of nursing.

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Research at University of Florida College of Medicine

Department of Anatomy

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A modern medical school department of anatomy might offer some surprises to the visitor who is returning for the first time since graduation, say 20 years ago. The spacious museums filled with jars of preserved dissections and startling anomalies are gone or have been reduced to a few out-of-the-way cabinets. The halls are no longer hung with pictures of famous name anatomists and former faculty. Instead, the museums have been converted into research laboratories and the halls now display pictures taken with the electron microscope. A closer look would reveal that the people in the laboratories are not doing special dissections on cadavers injected with colored starch or looking through conventional microscopes at histologic slides stained with hematoxylin and eosin. They are working at chemical benches with enzyme preparations and radioactive tracers. They are injecting hormones or the newest cancer-suppressing drug into mice, or examining the fetuses of a pregnant rat treated with an antimetabolite. They are working at sterile hoods with tissue cultures or in sterile rooms implanting electrodes into the brains of monkeys.

Scope of Anatomical Research

Our visitor by now may have asked with some incredulity, "This is Anatomy?" The answer would have to be a qualified one. It is not pure morphology of the sort most often practiced by the medical school anatomist of 50 or even 20 years ago. Nevertheless, these are modern anatomists who are using structural criteria and morphological end-points in their research. The main difference is that the end-points are no longer sought by direct observation alone; they are searched for with electron microscopes, chromatographic columns, conditioned reflexes and radioactive tracers. But can research which relies on such methodology really qualify as anatomical research?

This question is not new and the most satisfactory answer this writer can give is that anatomical research is whatever anatomists do when they do research, a definition which tends to leave the subject wide open. In fact, this openendedness is often cited as an advantage by those whose responsibility it is to recruit young men and women into this discipline. It is emphasized that people doing research in a department of anatomy feel very little restriction in selecting either their subject or their methods. Accepting the one qualification that morphological criteria or end-points will be used, the researcher still has as his sphere virtually the whole of biomedical science.[1]

A tendency to disregard categorical boundaries in research is, of course, not unique to anatomists; it is practiced to some degree in most areas of scientific inquiry today. The anatomist feels a bit less restrained than others only because he has never been quite sure where the boundaries of his discipline were anyway. Consider the matter of magnitude; an almost infinite series of structural problems exists between the gross and the ultramicroscopic levels. Then there are the multitudes of problems met when one interrelates structure with other aspects of living matter such as function, metabolism, growth and chemical composition. Because he is thus obliged to take a broad view, the thoughtful anatomist actually regards himself as much a human biologist as a specialist in medical basic science.

While on the subject it might be noted that this lack of restriction in point of view and in research activity is not an unmixed blessing. For example, the anatomist may teach one subject such as gross anatomy and do research in quite a different one such as electron microscopy. He must then maintain a high degree of competency

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in two areas that do not overlap to any noticeable dergee, unlike his colleagues in other disciplines who often teach and do research in one fairly circumscribed subject area. This is no small problem at a time of such rapid scientific expansion that it is virtually impossible to keep abreast of new developments in only one field. Furthermore, the research diversity among his colleagues, not to mention the subdivisions of teaching within his department, can make the present day anatomist feel like the people who built the Tower of Babel, confounded by a confusion of tongues.

Before discussing research in any other particular, a word about its quantitative aspects may be in order. In a recent survey[2] on the research output of all departments of anatomy in the United States and Canada, the Department of Anatomy at the University of Florida ranked twenty-sixth among the 97 medical schools reporting. We take modest pride in this rank, in view of the fact that our research laboratories were first opened in September 1956. Quality in research is a more nebulous thing and the reader is left to estimate it in his own way from the following descriptions.

Specific Projects

Our broad interest in human biology is exemplified by the work in physical anthropology and growth being carried on by Dr. James A. Gavan. Physical growth is such a standard property of living matter it is usually taken for granted, little attention being given to the environmental and genetic factors which influence it. In order to study the effects of nutrition, heredity, sex and population density upon growth, Dr. Gavan maintains a colony of some 60 monkeys at the University's excellent animal farm. Beginning at birth and at regular intervals thereafter the young animals are weighed, x-rayed and otherwise assessed as to their change in physical size and proportion. The data are then analyzed with an electronic computer in such a way that otherwise inapparent fluctuations become readily visible. As a sideline and because of his expert knowledge of skeletal structure, Dr. Gavan is frequently called upon by law enforcement agencies in the state to aid in the evaluation of skeletal remains that may have medicolegal significance, that is, the age, sex, race, and type and duration of burial of human bones unearthed at a construction site.

Research on the nervous system is centered on the cerebellum, a structure of which the functions are just beginning to be clearly defined. Dr. Donald C. Goodman has attacked the problem of cerebellar function by the very logical means of studying a series of animals in which this organ becomes increasingly more complex. He began with the frog, the earliest animal phylogenetically to have a cerebellum worthy of the name. After analyzing the physiology of this relatively simple organ, it was then somewhat easier to proceed stepwise to unravel the functional complications of the organ in successively higher animals such as the alligator, the duck, and the rat. By direct electrical stimulation of the cerebellar cortex, Dr. Goodman elicits complex patterns of locomotor and postural movements. These can be reversed, modulated or otherwise modified depending upon the specific area of cortex stimulated. Contrary to previous thinking on the subject, areas of comparable function in the cerebellar cortex are now known to be laid out in longitudinal bands rather than localized within the anatomical lobules. Dr. Goodman is extending his studies on the control of posture, movement and muscle tone into the brain stem and to other parts of the nervous system. These basic investigations may contribute to a better understanding and consequently to a more rational treatment of motor disorders such as spasticity, dystonia and dyskinesia.

Another very interesting approach to experimental neurology is being made by Dr. James A. Horel who is using a modification of the classical technique of the conditioned reflex to identify some of the pathways of learning. Rats are conditioned to make a postural response to an audible tone, but unlike the usual conditioning situation, the posture is elicited by electrically stimulating the cerebellum through implanted electrodes. After several simultaneous stimuli the tone alone is able to elicit part of the postural response. It has also been found that other areas of the brain than the cerebellum are subject to this unconventional sort of conditioned reflex and attempts are now being made to condition animals to a tone not only for postural but also for emotional responses elicited from the brain stem. If in any degree successful, this technique will provide a very valuable tool for elucidating the neuroanatomy and neurophysiology of learning and of the emotions.

Directly applicable to clinical medicine are the studies of Dr. Joseph F. Gennaro on the treatment of the bites of venomous snakes. These have been done in conjunction with Dr. Newton C. McCollough of Orlando and are summarized in two papers published in this Journal in June 1963. Dr. Gennaro's research interests, however, are not

limited to snakes and snake-bite treatment but extend to include the mechanisms of toxicity of natural poisons generally, including those produced by bacteria and such exotic forms as the octopus. He has developed methods for labeling venoms with radioactive tracers so that their localization in vivo and their ultimate sites of action may be more easily identified. He has also devoted much time to the fractionation of venoms into component enzymes by electrophoretic means. At present he is investigating the use of nonspecific substances such as chelating agents and sulphydryl drugs to counteract certain natural toxins.

The electron microscope has added a new dimension to the study of structure, increasing microscopic vision from 1,500x to 150,000x. Dr. William Callahan is our expert in the operation and application of this particularly intricate instrument. At the moment he is attempting to increase the precision of the electron microscope as an investigative tool by developing better "staining" methods. The usual histological stains are useless here and in order to achieve any degree of differentiation between various cellular components, an electron opaque material such as heavy metal ions must be selectively deposited on formed elements within the cells. Standard methods use lead or uranium compounds but these leave much to be desired. Dr. Callahan has just completed a study which reveals that certain vanadium compounds have superior staining properties and promise to add very significantly to this rapidly developing field.

Histochemistry has more than fulfilled its earlier promise as a means of revealing the chemical composition of tissues and cells. Dr. E. Marshall Johnson is currently applying histochemical methods to very good advantage in his research into the mechanisms of abnormal development. He uses folic acid deficiency in pregnant rats to cause maldevelopment of the offspring. The structural deviations caused in the embryos by this deficiency are well known, even in their earliest visible manifestations. Dr. Johnson, however, is tracing the abnormality back beyond the earliest structural defects and into the realm of the prior alteration in cellular chemistry. With his own adaptations of histochemical and electrophoretic methods he is showing that phosphatases, esterases and other enzymes are present in diminished quantities well in advance of the first recognizable malformation.

Also interested in the general area of embryonic development is Dr. David Peck who grows embryonic tissues in culture in order to observe the effects of varying environmental conditions on subsequent cellular differentiation. He has shown that the retina removed from an early chick embryo will develop to a surprisingly normal degree, with the usual nervous and receptor elements, if left intact under optimal culture conditions. If the retinal cells are dispersed at the time they are transplanted from the embryo to the culture, however, they develop in a different fashion. They remain as solitary cells, they fail to develop nervous processes typical of retinal cells, and most surprisingly, they become heavily pigmented, something normal retinal cells never do. Thus, whether the cells remain associated or become dispersed appears to be all important in determining precisely what developmental information is released from the genes, or at least how it is expressed.

The causation of congenital malformations is a subject much highlighted in recent months, so much so that it has won new enthusiasts almost to the point of obscuring the fact that a few scientists have worked in this field for a number of years. The writer is among these relative "old timers" who have tried to elucidate the mechanisms of teratogenic action by studying experimental animals treated with such agents as nutritional deficiencies, x-rays, and various toxins and antimetabolites. The upshot of these experiments, together with careful analysis of the human situation, seems to be that only a small percentage of malformations can be attributed to single genetic or single environmental causes and that a majority must be attributed to the interaction of two or more genetic and or environmental causes. The writer is presently investigating this hypothesis in rats and has succeeded in demonstrating several instances in which minimal or subthreshold levels of two teratogenic agents applied simultaneously have potentiated each other to the extent that a high percentage of malformed offspring resulted. Whether comparable potentiative effects occur during human pregnancy remains to be determined.

Thus, the anatomist of today no longer discovers new fascial layers or describes the inevitable structural variations encountered in the dissecting room. As a matter of fact there is some doubt that his predecessors would have regarded him as an anatomist in the true sense, at least as far as research activities are concerned. Never-

theless, the modern anatomist would rationalize such harsh judgment with the contention that he, like his more stereotyped predecessor, is also making a contribution to basic medical knowledge, albeit by somewhat different means.

Objectives

These research activities are currently supported by eight grants in the amount of approximately $125,000 from such agencies as the National Institutes of Health, the National Foundation and the United States Army. In addition he graduate program of the Department is supported by an Anatomical Sciences Training Grant in the annual amount of $26,000 from the National Institutes of Health. Ten graduate students are now working in this program toward Ph.D. degrees and it is expected that the number will reach 12 and possibly 14 during the coming year. Although our primary functions are teaching medical students and contributing to medical knowledge through research, efforts must also be devoted to the training of personnel to fill medical teaching and research positions in the future if quality in these areas is to be maintained. Thus our work becomes doubly gratifying in the realization that we are helping to train, not only the physicians, but also the medical educators and researchers of tomorrow.

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Woman's Auxiliary

How May the Auxiliary Further Mental Health?

Everything begins at home—not just charity. The beginnings, the developments and the adjustments are the foundations for one's present and future living at home, in the community, in the nation and in this world.

Since everyone combines to make up a community and its inseparable mental health, everyone is responsible for community mental health. People constituting communities definitely are increasing their awareness of this responsibility, as evidenced in countless forms of interest and activity.

The public has been educated to the point that proper guidance is a MUST—the lack of it would be disastrous. Right now people are looking impatiently for leadership, direction and adequate counseling in their immediate steps.

Only recently at the FAMH October Conference was this exemplified beyond a doubt. An often repeated question was "What can we tell the housewives to do if they notice someone in the home showing signs of emotional illness or difficulties?" The question received no definite answer—until one minute before the close of the session I felt driven to say "With mental illness being considered as just one of the many medical illnesses, and with people calling a doctor for any of the other medical illnesses, it seems to me that a doctor should be called for such an illness, too. Then, should the situation be one that would be handled better by someone else, the doctor would know to whom the situation should be referred." The ensuing dead silence was followed by the statement "Since there is no time for further questions or discussions, we are adjourned."

My observation seemed to me to be such an obvious answer to the question that it shouldn't have had to be stated. But people have to have things S-P-E-L-L-E-D out to them so much now-a-days, sad commentary on present day living though it is. How could it be otherwise when people deny themselves the constructive, free thinking moments of walking without a transistor radio in hand, of driving without playing the car radio, of returning home without bringing in the immediate sounds of the TV or radio?

The time has come for MDs to emerge from the background and go into action for the benefit and improvement of their community's mental health, thereby providing the looked for leadership, improving the "Doctor image" and tangibly proving their dedication to service and humanity. "Footprints in the sands of time were not made by sitting down"!

The Woman's Auxiliaries have Mental Health committees, and all but Manatee, Marion, Polk and Putnam of the 41 Florida County Medical Societies have such committees to approve and coordinate the Auxiliary plans of action.

The unlimited usefulness and possibilities of our Florida County Auxiliaries are determined by the respective medical societies. Emphasis on auxiliary Mental Health has been approved on national and state level, making possible the October distribution of Mental Health Program Kits.

Won't each County Medical Society PLEASE acquaint itself with this material for consideration and hoped for approval—then encourage, support and even assist its auxiliary in its number one need of serving and bettering each individual community's Mental Health toward the benefit of mankind generally? "Some folks may doubt what you say, but everybody will believe what you do."

Mrs. Frederick L. Patry

President's Page

Confusion and Bitterness

The two nouns in the title of this letter are frequently related. Misconceptions and a lack of understanding may breed distrust or lead to resentment. Specifically, reference is made to the recent agreement between the Florida Medical Association and the Florida Industrial Commission in which there is a revision of the fee schedule previously used since September 1, 1960. Standard code numbers and nomenclature, developed in the 1962 Relative Value Studies of the Florida Medical Association, form the basis or frame of reference for this unpublished schedule of fees. It is intended that physicians be given the opportunity to bill their usual or customary fees for services rendered to Workmen's Compensation patients. In the event that procedures are unusual or progress complicated, these facts may be substantiated by a narrative report. The unusual case record is then reviewed by the Medical Consultant and/or the Medical Advisory Committee. The latter group consists of representative members of the medical profession. They are aware that no single fee can be assessed which will cover all of the varied circumstances of medical or surgical services. Consequently, fair consideration, including the point of view of organized medicine, may be obtained.

For several years the interposition of a third party has encroached upon direct physician-patient relations. Many efforts have been made to preserve the freedom of medicine and to maintain the profession as a private enterprise. This is another such effort. The omission of fixed fees is a part of that philosophy. Months of study, and of dedicated effort, by our Committee on Fee Schedules, the Council on Specialty Medicine and consultation with other members of the Florida Medical Association, resulted in a compensation schedule which seemed to offer a fair solution for all concerned. A spirit of cooperation and of objective, factual discussion characterized these meetings, attended by people who are knowledgeable in the subjects under consideration. Admittedly, in retrospect, it would have been preferable to delay the effective date until after an intensive educational program had insured complete understanding of the changes made. It has been my privilege to observe closely the members of our Association principally concerned and responsible during the long period of consideration. There has been no conniving and no double dealing. Seldom has a group addressed itself to a task with such abandonment of self interest or with such devotion to the accomplishment of an idea which they believe to be for the good of all concerned. They deserve our warm thanks and appreciation.

Further information will be provided. Undoubtedly, there will be individual instances where inequities seem to occur. The Medical Consultant and the Medical Advisory Committee are not only available for consultation, but anxious to help when the complaint is just and reasonable.

At the meeting of Presidents and Secretaries of County Societies, which will be held in Orlando on the twenty-fifth and twenty-sixth of this month, a part of the program will be devoted to a discussion of Workmen's Compensation problems. This is a part of the Panel on Medical Economics.

Dissemination of facts concerning the happenings and current developments within the Florida Medical Association is often difficult. This Conference of Presidents and Secretaries provides a medium for the exchange of ideas and for freedom of expression. Be sure that your county medical society is represented. The agenda covers most of the activities of your Association, and provides a sort of interim session at which every member can make a contribution toward the solution of problems which confront us. Interested component county societies provide the strength of the state organization. Knowledge of the facts and awareness of the motivation behind decisions will dispel many doubts about the subject under discussion. The problems and desires of the membership of constituent societies should be freely expressed. In this way, our program of activities in the State Association will be truly representative of organized medicine in Florida.

Here is a plea for patience, and a combined effort on the part of all of our members to do everything possible in an effort to make this new program fair and effective for medicine, for the patient, the insurance carrier and industry. Better medical services will be performed by physicians who are free to do their best, and who will receive adequate remuneration, than by a system of regulation and fixed decrees, whether it be of fees or procedure. Modification of the present schedule can be made if the plan does not prove to be realistic or feasible. But give it a chance, first. And, without confusion, there will be no bitterness.

Warren W Quillian



Pharmaceutical Advertising

The purpose of advertising is to disseminate information about a product or an available service in the hope of creating a favorable impression and, in turn, of increasing sales. This general statement is true of the advertisements in this and other medical journals published throughout the country. There is, however, an additional objective in the messages of the pharmaceutical concerns for they represent an effort to help the physician know how best to help his patient.

When we physicians prescribe a drug preparation, do we ever consider the series of events preceding the decision to do so? Obviously, something brought this preparation to our attention; a colleague who had a case similar to one of ours had mentioned it at a staff meeting, a sample with various pieces of literature had come by mail, the detail man seen briefly at the end of a busy day had described the medication, or possibly an advertisement in a journal had caught our eye. Some, or all, of these occurrences usually precede the decision to write a particular prescription or use a particular pharmaceutical compound. Should we be even more curious, we might wonder who reported good results with this particular method of management to the colleague who first mentioned its use to us.

Recently a pharmacist employed by a chain of drug stores in the southern part of the state commented that he could determine when an advertisement for a new pharmaceutical preparation had appeared in The Journal of the Florida Medical Association for its appearance was immediately followed by an increase in the number of prescriptions for that particular preparation. The remark was encouraging to the staff of The Journal for it indicated that Florida physicians read The Journal and utilize the knowledge obtained from its advertisements.

Through reprints, samples, leaflets, letters, detail men and professional journals, each pharmaceutical advertiser makes an effort to contribute to our continuing education. Those of us who close our mind to this available help are giving our patients less than our best.

With this issue of The Journal there begins a series of reminders to help each of us remember to read the advertisements in each issue, to appreciate the help they may give, and to utilize the information offered when it is to the best interest of the patient. When a detail man is next shown into the office, thank him, and his employer through him, for making possible this up-to-the-minute, helpful system of self education which is presented to us through The Journal.

T.M.

The Changing Times in Medical Practice

"The end of the nineteenth century marked the passing of the horse and buggy days and the grand old family doctor—patient and capable, considering what he had to work with." Thus Dr. William W. McKibben closes his revealing article on practicing pediatrics at the turn of the century. To those of us who are privileged to know Dr. McKibben, there is much inspiration to be had from the complete dedication to Medicine of a man who has been engaged in active practice for more than 50 years.

The effectiveness of medication and methods of treatments available to us now is brought home with startling clarity when he discusses scarlet fever, a diagnosis which struck fear in the hearts of parents and doctors alike in the days Dr. McKibben recollects. Modern bacteriological methods can rapidly identify the beta hemolytic streptococcus, and one injection of long-lasting penicillin is effective in curing and preventing complications. Yet the lesson learned by observing lower mortality when adequate ventilation of wards was possible, still benefits us today.

Diphtheria, typhoid fever, syphilis and malaria are all to most young pediatricians names of diseases of which most of their information is hearsay. We now have a specific curative agent for each of these diseases. The privilege of watching the recovery of a child with diphtheria saved by intubation must have been a source of great satisfaction to practitioners in that time. Seeing malaria as a public health problem succumb to measures eliminating anopheline mosquitoes must have been a great thrill to men of that era. Some of their enthusiasm must have been transmitted to us.

Present day methods of handling arthritis, diabetes mellitus, anemia, and pertussis become more remarkable than ever when viewed in the light of Dr. McKibben's reflections. Cortisone, insulin, effective vaccines all are seen as powerful tools when looked at in this perspective.

Yes, a great deal of scientific progress has been made since that era, but it is fervently to be hoped that the heritage of patience and dedication to service has not and shall not be overlooked in practice with our new-found knowledge. Indeed there are many clinical problems yet unsolved. Daily we are confronted with evidence of them in the practice of medicine. The answer must lie in continued education, intelligent research, and a progressive attitude of accepting new constructive methods. The example set by men like Dr. McKibben is the stimulus and should hearten us to renewed efforts.

James W. Lancaster, M.D.
Coral Gables

Practice of Medicine By Noncitizens

The Florida Medical Practice Act provides that nonlicensed physicians can practice in hospitals in Florida as interns and residents for a period of two years. This, however, does not apply to hospitals which have approved training programs.

In those hospitals which have approved training programs, an unlicensed physician can remain as long as is necessary for him to complete his training in any given specialty. He is not allowed to complete the training in one specialty and then begin another. It is recommended by the Florida State Board of Medical Examiners, and also by the hospitals, that those trainees who have completed two years of their training become licensed because as residents they are in fact practicing medicine. Those foreign physicians who are in training, however, cannot become licensed until they obtain citizenship.

There has been considerable difficulty with foreign house physicians in hospitals which have no accredited training programs. According to law they can remain only two years in a Florida hospital without a license. They, of course, feel they are discriminated against if not allowed to stay indefinitely, or if they cannot go to another hospital and stay another two years or longer.

Because the Board was insisting upon conformity to the law, a special bill was introduced and passed in the 1963 Legislature to the effect that a foreign physician who holds a license in the country of his origin could remain as a house physician in a hospital for five years. This law applies only to Monroe County. The Board of Medical Examiners is studying the feasibility of invalidating this law in the courts.

As we all know, it was the purpose of the 1961 Legislature to upgrade the quality of medical practice in Florida by requiring foreign graduates to be certified by the Educational Council for Foreign Medical Graduates and by prohibiting foreign graduates from continuing practice in Florida hospitals for more than two years.

Homer L. Pearson Jr., M.D., Director
State Board of Medical Examiners of Florida
Miami

Association News

Allergy

Allergy, as a specialty, did not really get started until the late twenties because of the skepticism and unwillingness of the profession to accept allergists. Those persons who react in an abnormal way to certain foods, inhalants, medicines taken orally or by injection, and objects contacted are the ones who have need of an allergist's care.

There are two groups of allergy problems—the major and minor types. The first is well known and includes asthma, hay fever, hives and eczema, which affect some 10 per cent of the population. The more minor ones are often missed; they comprise an additional 20 to 30 per cent. Any afebrile disorder that recurs often and has be-

come chronic, suggests an allergy. Such problems are head colds, sinusitis, bronchitis, fever blisters, canker sores, headaches, migraine, croup, colitis, severe colic, unexplained fatigue, itching of the skin, with or without a rash, and others.

When a patient requests an allergy study, the first, and by far the most important factor is the history. An allergist wants to know when the trouble began, how often it recurs, if it is perennial or seasonal or both, if it is worse in his own home and on week ends, if it is influenced by sudden weather changes or winds, if other systems of the body are affected, if emotions are a contributory factor, and other details. Should there be a family history of allergy, it enhances the diagnosis of the condition. Such a history is time-consuming but absolutely necessary. It requires at least an hour.

The usual physical and laboratory tests are similar to those other physicians make. At times, additional data such as x-ray, nasal smears, leukopenic index, and pulmonary function tests are helpful. Like a detective, once the history is obtained, an allergist hunts for additional clues. These clues are local responses to skin tests. Multiple tests of various foods and inhalants are applied to the skin, first on superficial scratched areas, then subsequently, since the scratch tests usually give negative results, they are made intracutaneously with the same substances. The substances tested are called food and inhalant antigens. Antigens are literally water-soluble extracts, mainly protein. These skin tests are inspected approximately 15 minutes later. Should there be a larger area of local irritation than a control test site, the test suggests a positive reaction. Such a positive reaction indicates the presence of circulatory antibodies and is a potential clue for one of the causes of the allergy. Antibodies are supposed to give protection, in nature, but like Dr. Jekyll they sometimes fail to do so, thus acting like Mr. Hyde.

Little children who have a morbid fear of needle injections, children and adults with a skin type of allergy, those who have dangerous allergic reactions and those who are unable to remain for one or two weeks for sufficient scratch and needle testing, can be skin-tested by the passive transfer (indirect) method of skin testing. They have to be free of contagious diseases. This method is a real godsend in such hardship cases.

Positive skin tests are then correlated with the patient's history. Foods that are positive in the history and skin tests are usually avoided for some six months or longer. Those foods consistently avoided or consistently disliked are usually also avoided. To prevent any vitamin or mineral shortage, a mixed vitamin and mineral liquid or capsule that meets minimal daily requirements is given. The diet should be sufficient to satisfy hunger and to avoid loss in weight. After six months a trial is begun to see if forbidden foods now agree; then they are gradually given again at three to four day intervals.

For inhalants, a treatment antigen composed of pooled antigens of offending pollens alone or with epidermal inhalants, dust and fungi, is given. The dosage is begun at a very low dilution which does not show a positive skin reaction on intracutaneous testing. Then it is gradually increased to the maximum strength or to the maximum dosage the patient can tolerate. Once that point is reached, the treatment antigen is administered less often, as weekly, during the season when the allergy is worse and less often at other times for some three years.

A few allergists are using repository antigen injections and believe they not only cut down the frequency of needed injections, but also give superior results. The two national allergy societies do not share that enthusiasm and think the accepted aqueous form of treatment is comparable. While double blind studies have been made in repository injections, there has been no use of P. E. or Chi Square such as immunologists employ to see if a certain study is really significant. Unfortunately, the costs of preparing the repository antigen are expensive and charges, of necessity, are greater; so economically the cost to the patient approaches the total cost of the usual aqueous treatment antigen.

Besides the avoidance of foods and antigen injections, an allergist must go into detail to show patients how to reduce environmental factors to a minimum. The more time spent explaining such, the far better the cooperation. Patients are told in the beginning their treatment is a long range one and the greater the cooperation, the better the results.

In the space alloted it is impossible to go into treatment of acute attacks of allergy. Antibiotics are seldom used by allergists and hydrocortisone preparations should be deferred until a thorough attempt by orthodox methods has failed. If used, hydrocortisone preparations had best be used in decreasing dosage for a few days or weeks only.

The main function of an allergist is to try to find the causes of the allergic disorder and then to remove causes and treat for inhalants that affect the patient. With thorough cooperation with his allergist, the patient can anticipate improvement to excellent results in three out of four cases. The word cure or guarantee should never be used.

W. Ambrose McGee, M.D.
West Palm Beach

Internal Medicine

The American Society of Internal Medicine was formally organized in Boston in 1957 with 27 state societies sending delegates. The American College of Physicians assisted in its founding, and has since maintained a close liaison. Florida was one of the states with charter societies, and its society has been a vigorous and growing group. At present almost every state has an active society. These organizations evolved because of a serious need for coordination of efforts directed to furthering the practice of internal medicine. Major objectives have been a study of the scientific, economic, social and political aspects of medical practice, and the furtherance of all worth while programs for improved patient care and the highest standard of practice in internal medicine. Close cooperation or liaison with all phases of organized medicine, national and state, has been essential for progress.

Increased awareness by physicians in other branches and by the public of the key role and importance of internists in clinical medicine was believed to be a need from the beginning. Another continuing objective has been to define and describe the characteristic services of internal medicine so clearly that their inclusion in all medical care plans will inevitably follow. The recent F.M.A. Relative Value Studies is an excellent step in this direction. A study of insurance trends, fee structures and objectives of various health insurance plans is maintained in a continuing effort to assist the medically ill patient to get adequate coverage for the services required. The proposition that the quality of medical care and the economics of medicine are inseparable has been accepted by the Society, and a study of medical audits and other means to improve the quality of internal medicine is under way. In these and in various other ways the members strive to improve the quality of medical care for the patient and the professional climate of Florida for the internist.

An early project of the American Society of Internal Medicine and component state societies was the formulation of a suitable definition of an internist. This stemmed from the impression that internal medicine, unquestionably one of the oldest, largest and most traditional of the specialist groups, had a hazy and confused public image. A number of definitions were proposed, none entirely satisfactory to all. Much has been said and written about the internist in lay periodicals and elsewhere in recent years, however, and he has become much more distinct to all. An acceptable definition of the internist might say that he is a physician who has had training after internship in diagnosis and in the treatment of medical diseases. His training has usually consisted of three years or longer of residency or fellowship in an accredited hospital. By virtue of this training and subsequent experience he is fully qualified as a diagnostician, consultant in medicine and personal physician for adults, family counselor, and

in the management and referral of medical problems. This elongated definition illustrates the difficulty in arriving at a brief pat description of the internist and, also, the multifaceted nature of his specialty. Many internists restrict themselves entirely or partly to special medical areas such as cardiology, gastroenterology or endocrinology, but all must be well grounded in clinical medicine. Some have wide consulting practices, many in urban areas have part time teaching duties, and some confine themselves rather largely to the care and diseases of the aged. It is difficult to profile the internist in Florida, as his clinical field is wide and the demand on his services varies from one area to another. It is certain that there is a great demand for the internist's services in Florida as his numbers are steadily increasing. Aside from the population growth of Florida it is thought that the preponderance of aged persons and the high quality of medical practice in Florida are important factors in this increase.

Membership in the Florida Society of Internal Medicine is open to internists who are certified by the American Board of Internal Medicine, or are members of the American College of Physicians. Prospective members must be approved by a Membership Committee. It is realized that there are many able internists in Florida who are not certified by the Specialty Board, but the Society has thought after considerable deliberation that in order to maintain a high standard of professional ability among members a line must be drawn at some point. Board certification has seemed the most reasonable requirement. It is believed that the objectives of the Society are shared by all internists in Florida, and there can be no question that its accomplishments are equally beneficial to members and nonmembers.

The Florida Society of Internal Medicine is recognized as a specialty group by the Florida Medical Association and has representation on the Council on Specialty Medicine. It has its annual meeting at the time of the annual meeting of the Association and has a council meeting twice yearly. While it is a relatively young organization among specialty groups, internists coming to Florida in increasing numbers make the Society a growing organization and an effective spokesman for the internists of the state.

FRED A. BUTLER, M.D.
TALLAHASSEE

Books Received

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GUEST SPEAKERS

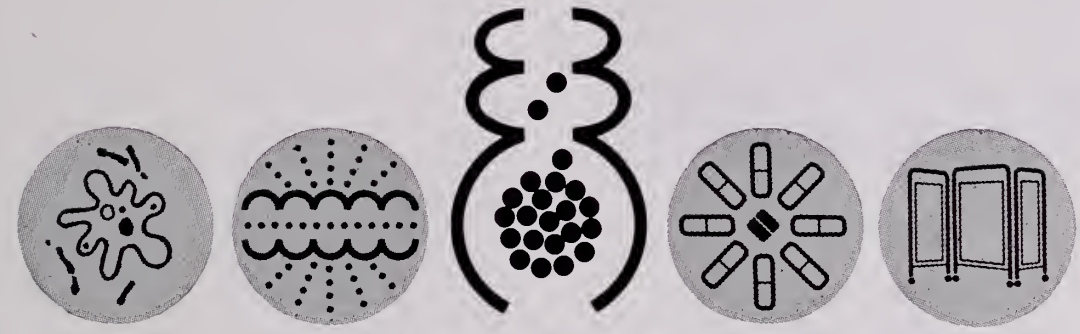
Nicholas M. Greene, M. D., New Haven, Conn.
Anesthesiology
Adolph Rostenberg, Jr., M. D., Chicago, Ill.
Dermatology
Arthur P. Klotz, M. D., Kansas City, Kans.
Gastroenterology
J. Roswell Gallagher, M. D., Boston, Mass.
General Practice
Roger B. Scott, M. D., Cleveland, Ohio
Gynecology
George R. Herrmann, M. D., Galveston, Tex.
Internal Medicine
William C. Thomas, Jr., M. D., Gainesville, Fla.
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John B. Reckless, M. D., Durham, N. C.
Neuropsychiatry
Robert A. Cosgrove, M. D., Jersey City, N. J.
Obstetrics
Roy O. Scholz, M. D., Baltimore, Md.
Ophthalmology
Otto E. Aufranc, M. D., Boston, Mass.
Orthopedic Surgery
Paul H. Holinger, M. D., Chicago, Ill.
Otolaryngology
Paul K. Lund, M. D., Seattle, Wash.
Pathology
Margaret Lyman, M. D., New York, N. Y.
Pediatrics
David S. Carroll, M. D., Memphis, Tenn.
Radiology
C. Barber Mueller, M. D., Syracuse, N. Y.
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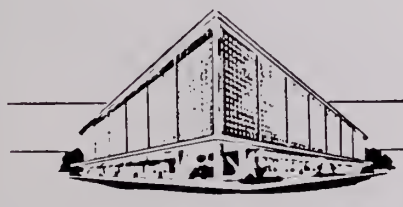
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News

The 27th Annual New Orleans Graduate Medical Assembly is being held on March 2-5 in New Orleans with headquarters in the Roosevelt Hotel. A total of 19 outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The names of the speakers appeared in the December issue and are repeated in this issue of The Journal.

Foundation of the Webster Merritt Historical Collection has been announced by the Duval County Medical Society in Memory of Dr. Webster Merritt who died on October 5. Several years ago a collection of antique medical instruments and other artifacts, photographs and manuscripts were presented to the Society by Dr. Merritt, the author of "A Century of Medicine in Jacksonville and Duval County." It is intended that this collection will be expanded, properly preserved and displayed. The Society invites donations of items of medical historical interests. Dr. Kenneth A. Morris of Jacksonville is chairman of the project.

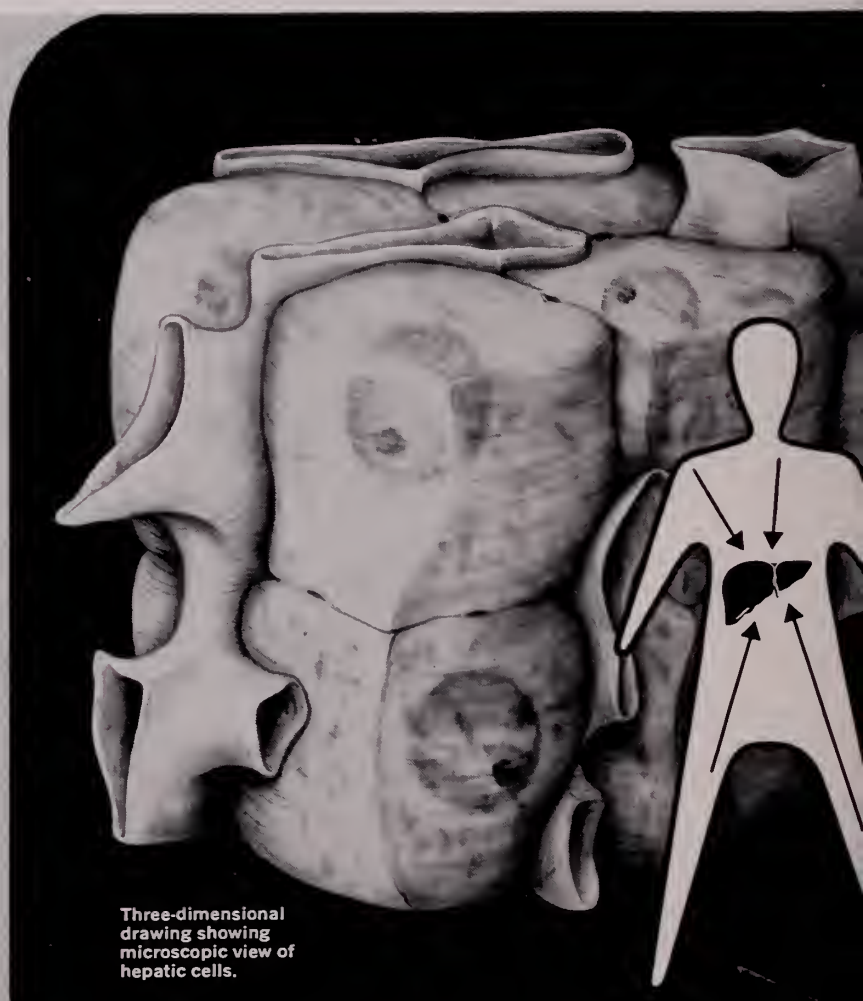
A postgraduate course entitled "Evolving Concepts in Pulmonary Disease" is being presented by the University of Miami School of Medicine on March 18-21 at the Fontainebleau Hotel at Miami Beach. Dr. Raymond E. Parks, Professor and chairman of the Department of Radiology at the University is director. Dr. Manuel Viamonte Jr., of Miami is chairman of the Scientific Program Committee, and Dr. Robert F. Feltman, of Miami is chairman of the Registration Committee.

The Bulletin of the Dade County Medical Association has been selected for the 1963 Honor Award for Distinguished Service in Medical Journalism among city and county publications by the American Medical Writers Association. The Bulletin was chosen because of its "accuracy, clarity, conciseness and newness of information; for excellence of design, printing and illustrations, and for distinguished service to the medical profession."

Dr. Edwin H. Updike of Ocala has been chosen president-elect of the Florida Division of the American Cancer Society, and Dr. Newton W. Larkum of Naples has been installed as president.

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A Seminar on the Newborn is being presented by the University of Florida College of Medicine on Jan. 30-Feb. 1 at Gainesville. Guest speakers on the program are Drs. Heinz Eichenwald, Professor of Pediatrics, Cornell Medical Center, New York; William Nyhan, Professor and Chairman, Department of Pediatrics, University of Miami School of Medicine, Coral Gables; Clement Smith, Professor of Pediatrics, Boston Lying-In Hospital, Harvard Medical School, Boston.

A Postgraduate Seminar in Anesthesiology is being held January 5-8 in the Eden Roc Hotel at Miami Beach. Sponsors are the Dade County Medical Association, University of Miami School of Medicine, Florida Society of Anesthesiology and the Miami Society of Anesthesiology.

The Sixth Annual Conference of County Medical Society Presidents and Secretaries is scheduled for January 25-26 at the Robert Meyer Motor Inn in Orlando.

The 1964 meeting of the Southeastern Surgical Congress will be held on the S. S. Hanseatic, sailing March 21 from Port Everglades and returning to this port on March 28. Dr. L. Washington Dowlen of Miami is second vice president of the Congress.

Dr. Robert E. Klein of Gainesville has been elected president-elect of the American Association of Blood Banks.

Dr. G. Dekle Taylor of Jacksonville has been appointed to the Executive Committee of the Section on Otolaryngology of the Southern Medical Association.

The Twentieth Annual Congress and Graduate Instructional Course in Allergy sponsored by the American College of Allergists has been scheduled for March 1-6 at the Americana Hotel in Bal Harbour, Miami Beach.

Dr. Hawley H. Seiler of Tampa has been elected president of the Southern Chapter of American College of Chest Physicians.

Drs. James D. Beeson of Jacksonville, George H. Mix of Melbourne, and Harold Carron of Tampa served as delegates in the House of Delegates at the recent annual meeting of the American Society of Anesthesiologists.

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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

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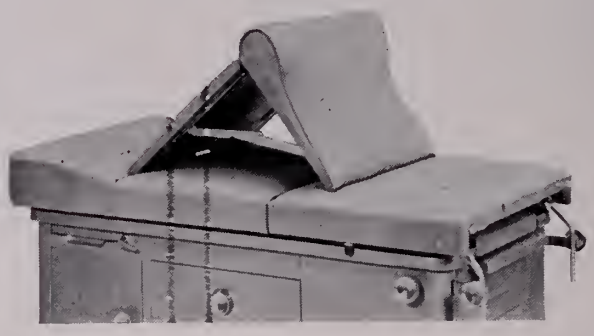
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[1] Simon, F. & Bernstein, A.: "The Treatment of Obesity in Patients with Cardiovascular Disease," Angiology, *12*:32-37, Jan. 1961.
[2] Plotz, M.: Modern Management of Obesity, J.A.M.A. *170*:1513-1515 (July 25) 1959.
[3] Bernstein, A. & Simon, F.: "Treatment of Obese Diabetics and Arteriosclerotics," Clin. Med. 907-920, May 1961.

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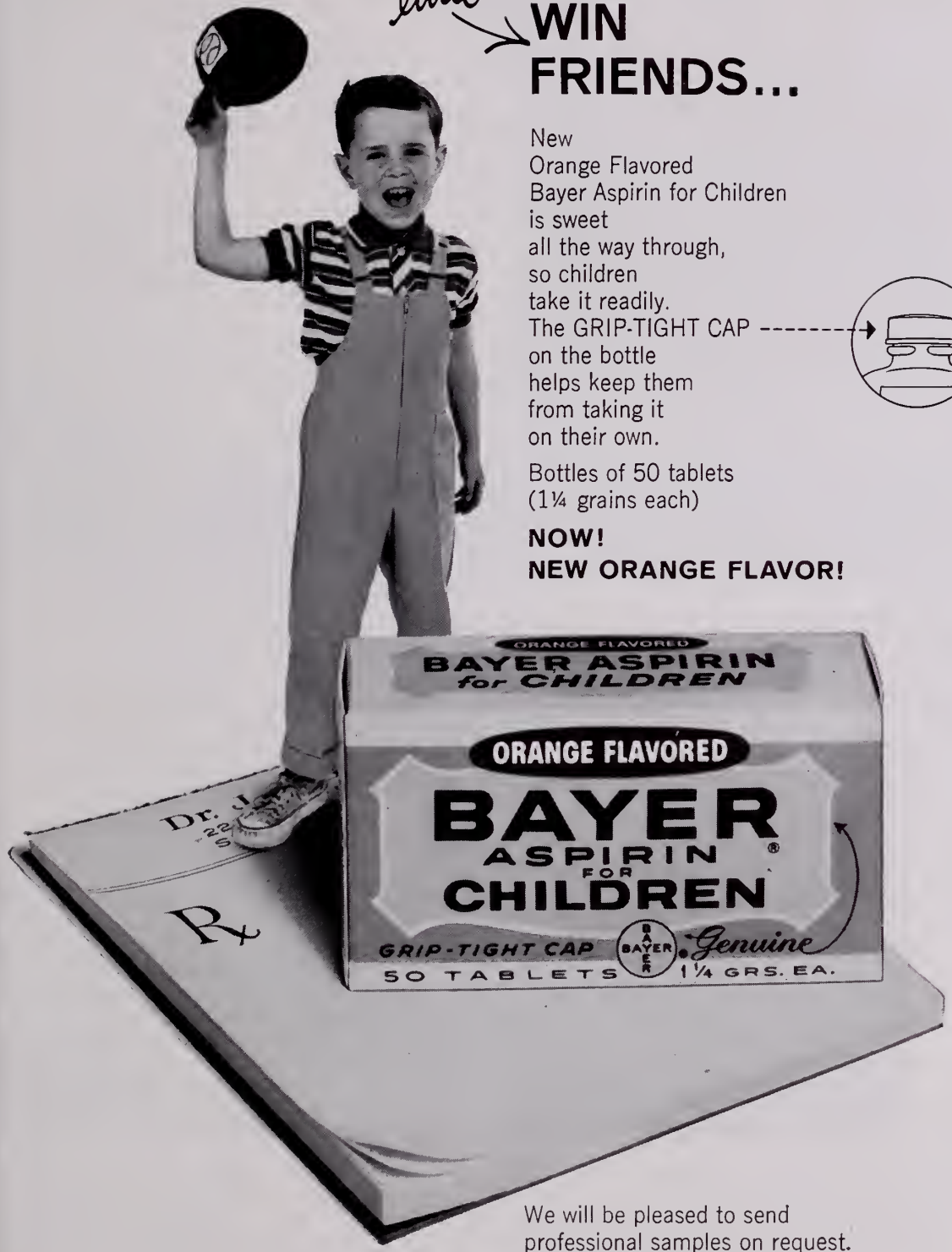
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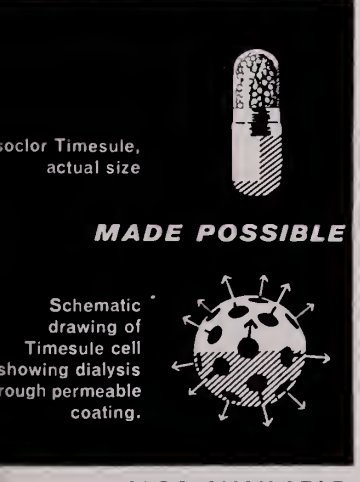
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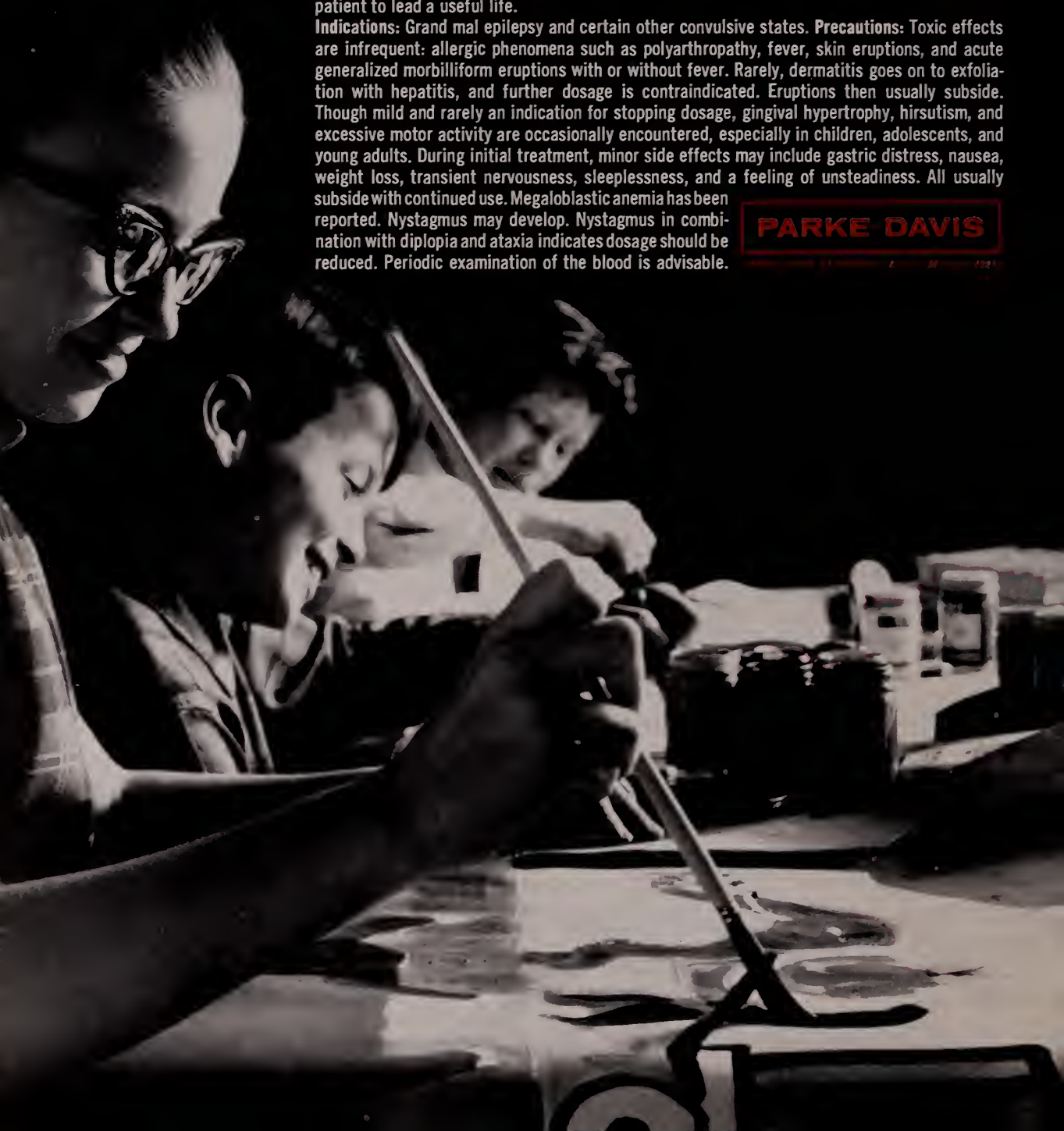
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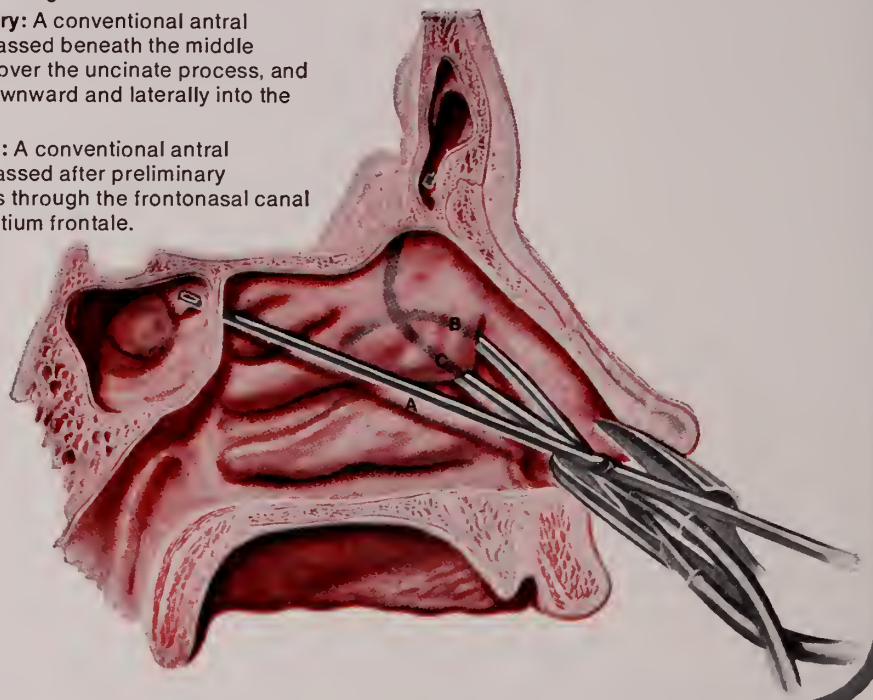
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*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

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Volume 51, Number 2, February 1964

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redient.

with any drug containing prednisone, Arthral-
-PR is contraindicated, or should be adminis-
tered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

*Cohen, et al: J.A.M.A., 165:225, 1957.

A. H. ROBINS CO., INC.
RICHMOND, VIRGINIA



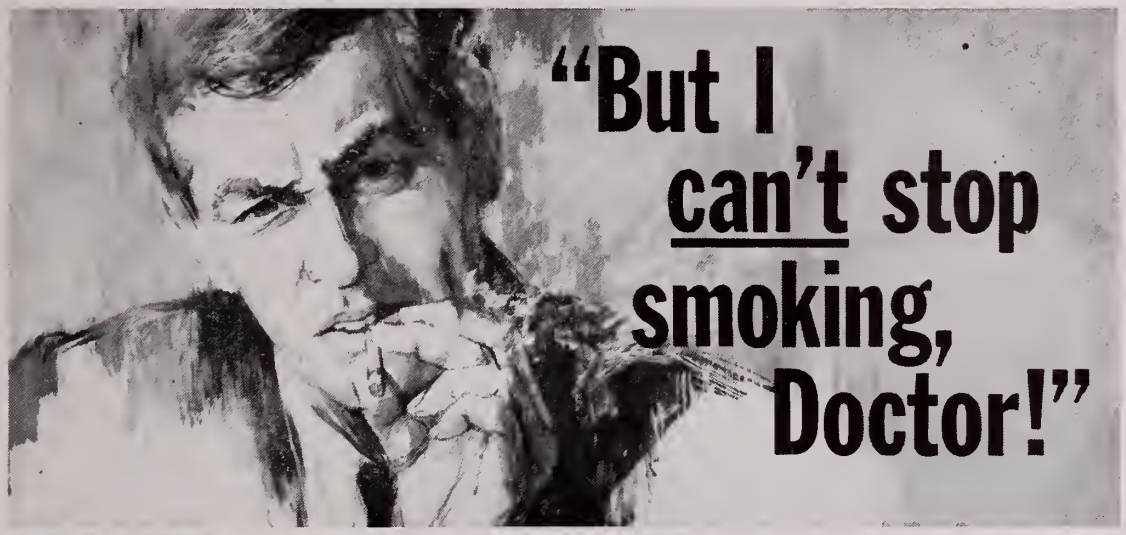
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Also: 'Empirin'® Compound with Codeine Phosphate*
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When your patient says:



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BRAND OF LOBELINE SULFATE, MRT

help curb the smoking habit

- Help induce a feeling of satiety similar to that of tobacco because of lobeline's pharmacological relationship to nicotine.
- Permit the patient to indulge his oral fixation by substituting the NIKOBAN Pastille for tobacco.
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- Encourage patient cooperation through pleasant taste.

Dosage and Administration: In order to obtain the maximum benefit, a NIKOBAN Pastille should be sucked slowly and taken according to the schedule below. Whenever possible a pastille should be taken after meals.

1st week: 1 pastille every 1 to 2 hours for a maximum of 12 pastilles daily. *2nd week:* 1 pastille every 3 hours. *3rd week:* 1 pastille every 4 hours. *4th week:* 1 pastille every 4 to 6 hours. *Thereafter* 1 pastille may be taken at infrequent intervals whenever necessary. In some instances there may at first be a slight astringent burr of the tongue and throat. This will usually disappear as treatment with NIKOBAN Pastilles progresses and is no cause for concern.

Caution: It is advisable neither to smoke nor to use a smoking deterrent during pregnancy.

Formulation: Each NIKOBAN Pastille contains 0.5 mg. lobeline sulfate in a pleasant tasting spiced-cherry base.

Availability: In packages of 50 pastilles.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, New York, Macmillan, 1960, Ed. 2, pp. 620-622; 2. Edmunds, C. W.: J. Pharmacol. and Exper. Therap., 1:27, 1909; 3. Hazard, R. and Savini, E. Gand., 92:471, 1963. 4. Dorsey, J. L.: Ann. Int. Med., 10:628, 1936; 5. Rasmussen, K. B.: Ugeskr.laeger, 118:222, 1956; 6. Ejrup, B.: Sven. lak. Tid., 53:2634, 1956; 7. Jochum, K. and Jost, F.: Munch. med. Wchnschr., 103:618, 1961; 8. Jost, F. and Jochum, K.: Med. Klin., 54:1049, 1959; 9. Smoking and Health, Summary and Report of the Royal College of Physicians of London on Smoking. New York, Pitman, 1962.

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Please send me a trial supply of NIKOBAN Pastilles.

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Special cough formula for children

Pediacof®

Each teaspoon (5 ml.) contains codeine phosphate 5 mg., Neo-Synephrine® hydrochloride (brand of phenylephrine hydrochloride) 2.5 mg., chlorpheniramine maleate 0.75 mg. and potassium iodide 75 mg.

soothing decongestant and expectorant



bright red, pleasant-tasting, raspberry-flavored syrup

Pediacof is different. It is designed especially for children, and each ingredient is in the right proportion. The potassium iodide in Pediacof is so well masked that it is virtually unnoticeable. Children like the sweet raspberry flavor of bright red Pediacof.

Dosage: Children from 6 months to 1 year, ¼ teaspoon; from 1 to 3 years, ½ to 1 teaspoon; from 3 to 6 years, 1 to 2 teaspoons; and from 6 to 12 years, 2 teaspoons. These doses are to be given every four to six hours as needed.

How supplied: Bottles of 16 fl. oz.

Available on prescription only.
Exempt Narcotic.

Side effects: The only significant untoward effects that have occurred are mild anorexia and an occasional tendency to constipation. However, discontinuance of Pediacof has seldom been required. Mild drowsiness occurs in some patients but, when cough is relieved, the quieting effect of Pediacof is considered beneficial in many instances.

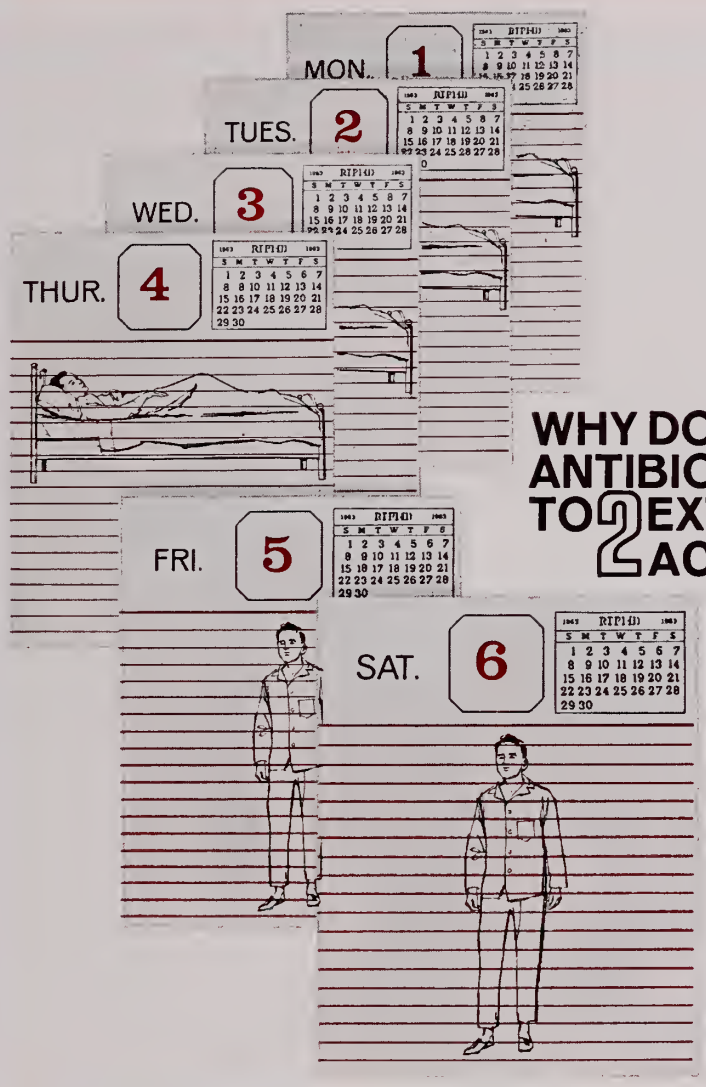
Precautions and contraindications: Patients with tuberculosis or those who are known to be sensitive to iodides should not be given Pediacof.

Caution should be exercised if Pediacof is administered to patients with cardiac disorders, hypertension or hyperthyroidism.

Warning: May be habit forming.

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Because it is more resistant to disintegration, has a lower renal clearance rate than earlier tetracyclines[1]...a favorable depot effect resulting from protein binding and greater mg. potency...all giving higher, sustained *in vivo* activity which continues long after the last dose.

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DEMETHYLCHLORTETRACYCLINE HCl

Effective in a wide range of everyday infections — respiratory, urinary tract and others — in the young and aged — the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.
Side Effects typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. The possibility of tooth discoloration during development should be considered in administering any tetracycline in the last trimester of pregnancy, in the neonatal period, and in early childhood. *Capsules*, 150 mg. and 75 mg. of demethylchlortetracycline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 mg. b.i.d. 1. Kunin, C. M.; Dornbush, A. C., and Finland, M.: Distribution and Excretion of Four Tetracycline Analogues in Normal Young Men. *J. Clin. Invest.* 38:1950 (Nov.) 1959.

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"They keep saying I'm sloppy!"



Nicozol® helps you restore your geriatric patients' interest in themselves

NICOZOL therapy can help you brighten the outlook of your aging patients who tend towards (1) untidiness, (2) irritability, (3) incompatibility, (4) lack of interest, and (5) loss of memory or alertness.

The NICOZOL formula helps improve mental acuity, increase the supply and use of oxygen in the brain, improve peripheral circulation—without excitation, depression, or other untoward effects.

NICOZOL can help you keep your aging patients actively alert and at ease with themselves, their families, and others.

Supplied: NICOZOL tablets (and capsules) in bottles of 100 and 1000. NICOZOL elixir in pints and gallons.

Precautions: May produce overstimulation in high doses. Discontinue if muscular twitchings or clonic convulsions occur. The flush produced in sensitive individuals is transient and harmless.

Average Dose: 1 to 2 tablets (or capsules) 3 times a day. 1 teaspoonful elixir 3 times a day.

Formula: Each tablet or capsule contains:
Pentylenetetrazol.....100 mg.
Nicotinic Acid.....50 mg.
Each teaspoonful (5 cc.) elixir contains:
Pentylenetetrazol.....200 mg.
Nicotinic Acid.....100 mg.
(as the sodium salt)
Alcohol.....5%

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LABORATORIES
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"Upon arising, nose was open". . . or how another happy patient describes the nasal decongestant action of Dimetapp Extentabs*—how would *your* patients describe it?/In Sinusitis, Colds, U.R.I., up to 10-12 hours' clear breathing on one tablet/Also available: Dimetapp Elixir, for t.i.d. or q.i.d. dosage.

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[Dimetane® (brompheniramine maleate), 12.0 mg.; phenylpropanolamine hydrochloride, 15 mg.; phenylephrine hydrochloride, 15 mg.]

A. H. ROBINS CO., INC., RICHMOND 20, VA.

*CLINICAL REPORT ON FILE, MEDICAL DEPT., A.H. ROBINS CO., INC.

BRIEF SUMMARY: *Indications:* Dimetapp reduces nasal secretions, congestion, and postnasal drip for symptomatic relief of colds, U.R.I., sinusitis, and rhinitis. *Side Effects:* In high dosages, occasional drowsiness due to the antihistamine or CNS stimulation due to the sympathomimetics may be observed. *Precautions:* Administer with caution in cardiac or peripheral vascular diseases and hypertension. *Contraindications:* Antihistamine sensitivity. Not recommended for use during pregnancy.



The discharged mental patient... and Thorazine®

brand of chlorpromazine

"The average practitioner is quite capable of handling the vast majority of ex-institutionalized patients by regulation of medication, reassurance, manipulation of the environment where necessary, and . . . other technics." Kline, N.S.: Postgrad. Med. 27:620 (May) 1960.

The family physician must often assume responsibility for the discharged mental patient. Thorazine (chlorpromazine, SK&F) can be a valuable adjunct to the continuing care of this patient, because it helps prevent relapses by insulating him from the impact of stressful experiences. For successful rehabilitation and prevention of rehospitalization, however, the former mental patient—and often his family—also needs the guidance and counsel of his physician.

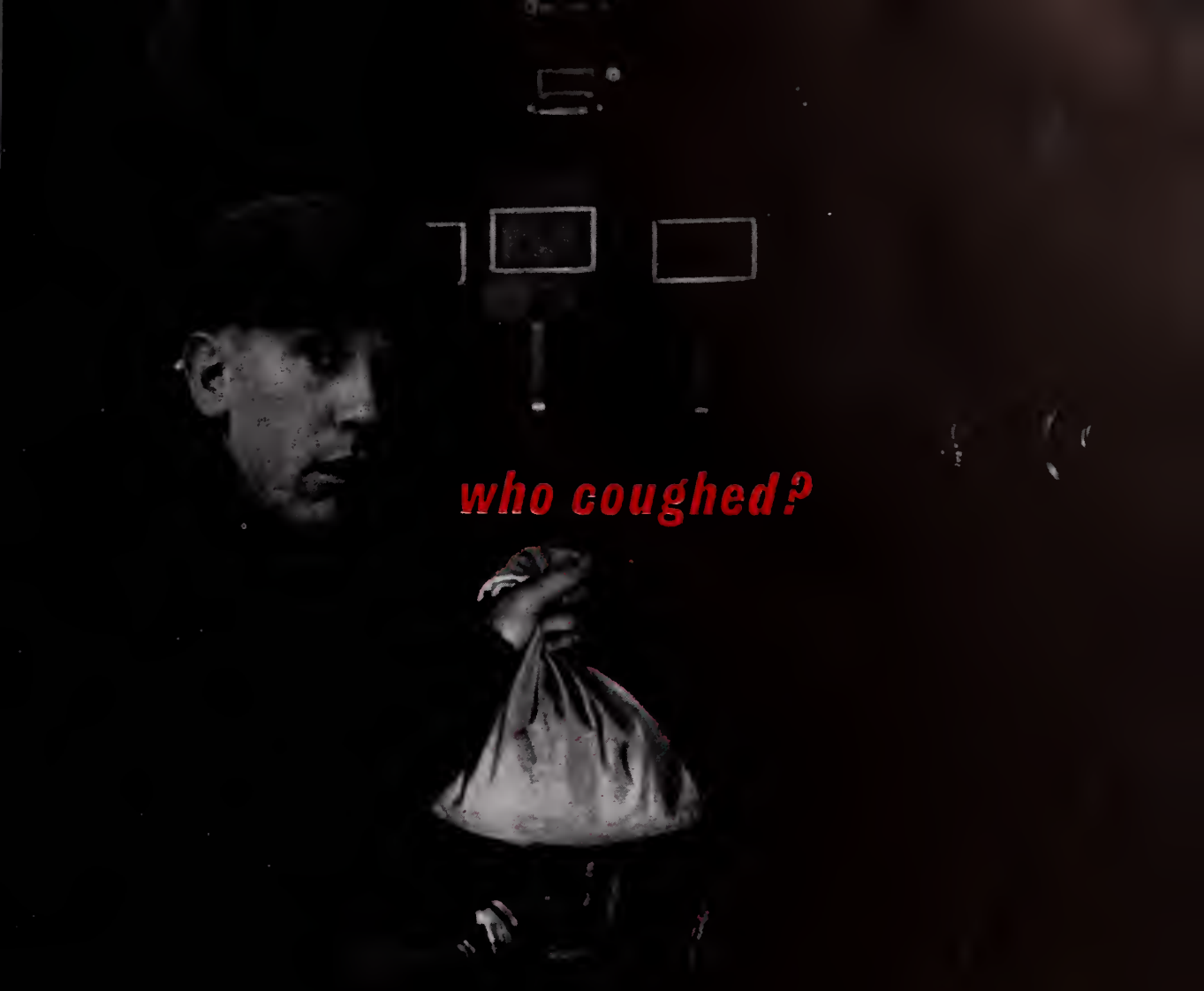
Many physicians are surprised by the high doses of Thorazine (chlorpromazine, SK&F) used in patients released to their care from mental hospitals. This surprise may be expressed by a drastic reduction in dosage "to play it safe"—with serious consequences for the patient.

The successful maintenance of former mental patients requires adequate, often "high" dosage, and often for prolonged periods of time. Fortunately, these dosages do not mean greater risks for the patient. On the contrary, there is much less risk of serious side effects once a patient has become gradually accustomed to Thorazine (chlorpromazine, SK&F)—*regardless of dosage*—over a period of a few months. Continuing therapy is almost always well tolerated, and is essential to most patients' continued well-being.

Brief Summary: Thorazine (chlorpromazine, SK&F) has been successfully used for 10 years in the treatment of mental and emotional disturbances, and has proven highly effective in the maintenance therapy of former hospitalized mental patients. *Principal side effects:* The most frequently encountered side effect is transitory drowsiness. Other occasional side effects include: dry mouth, nasal congestion, constipation, miosis, dermatological reactions, photosensitivity, jaundice, hypotension, increased appetite and weight; very rarely, mydriasis, agranulocytosis, extrapyramidal symptoms. *Contraindications:* Comatose states or in the presence of excessive amounts of C.N.S. depressants.

For complete prescribing information, please see *PDR* or available literature.

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HYCOMINE SYRUP

Each teaspoonful (5 cc.) contains:

Hycodan®	
Hydrocodone bitartrate . . 5 mg.	
(Warning: May be habit-forming)	6.5 mg.
Homatropine methylbromide 1.5 mg.	
Pyrilamine maleate	12.5 mg.
Phenylephrine hydrochloride	10 mg.
Ammonium chloride	60 mg.
Sodium citrate	85 mg.

in a highly palatable, cherry-flavored vehicle (methylparaben 0.13% and propylparaben 0.02% as preservatives)

INDICATIONS: For both productive and nonproductive cough. For relief of symptoms in tracheitis, bronchitis, pneumonia, pharyngitis, bronchial asthma, pertussis, and allied conditions; cough associated with allergy; in general, whenever cough medication is indicated.

DOSAGE: Average adult dose—1 teaspoonful after meals and at bedtime with food. Children 6 to 12 years, ½ teaspoonful; 3 to 6 years, ¼ teaspoonful; 1 to 3 years, 10 drops; 6 months to 1 year, 5 drops; after meals and at bedtime. On oral Rx where state laws permit. U.S. Pat. 2,630,400.

CAUTION: Should be used with caution in patients with known idiosyncrasies to phenylephrine HCl and in patients with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients use should not exceed three days. Hycomine Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur. May be habit-forming.

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Literature on request

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No need to write three separate prescriptions for antitussive, decongestant and analgesic relief of common cold, flu or grippe symptoms when it is therapeutically correct... economically sound...to specify

ANTITUSSIVE/DECONGESTANT/ANALGESIC 'EMPRAZIL-C'® TABLETS

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Phenacetin	150 mg.
Aspirin	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming

'Emprazil-C' Tablets are available on prescription only.

Dosage: Adults and children over 12 years—1 or 2 tablets—3 times daily as required. Children 6 to 12 years—1 tablet—3 times daily as required. **Caution:** While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed. **Supplied:** Bottles of 100 tablets.

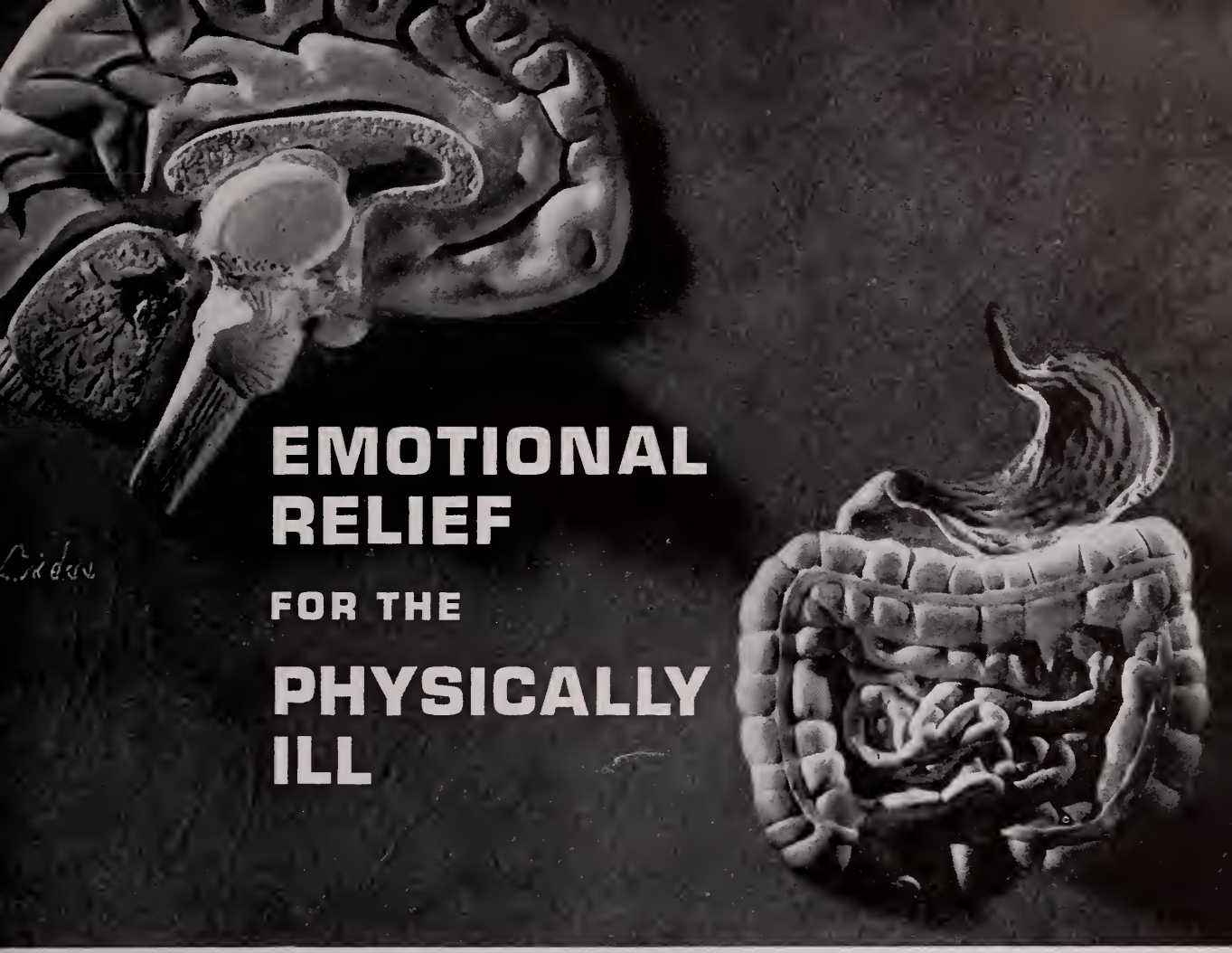
Also available without codeine as 'EMPRAZIL'® TABLETS

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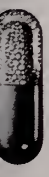


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All day long
. . . keeps the patient calm,
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All night too
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(MEPROBAMATE 400 MG. SUSTAINED RELEASE)

Simplified, convenient dosage for emotional relief.

ide effects: 'Meprospan' (meprobamate, sustained release) remarkably free of untoward reactions. Daytime drowsiness as not been reported. Rare allergic or idiosyncratic reactions nay occur, generally developing after 1-4 doses of the drug.

Contraindications: Previous allergic or idiosyncratic reactions o meprobamate contraindicate subsequent use.

recautions: Should administration of meprobamate cause rowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity equiring alertness should be avoided if these symptoms are resent. Effects of excessive alcohol may possibly be increased y meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage.

Complete product information available in the product package, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Supplied: 'Meprospan'-400 (meprobamate 400 mg.), 'Meprospan'-200 (meprobamate 200 mg.), each in sustained-release capsules. Both potencies in bottles of 30.

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This pin is 0.00032 of an inch larger than perfect. As a result, it is rejected. ■ Stainless-steel pins like this are used to mold Lilly capsules. From each tray of three hundred new pins, fifty are selected at random. The diameter, length, taper, contour, and finish are carefully measured. If the sensitive electronic measuring devices show an imperfection beyond the hairsplitting limits, the entire tray of three hundred is rejected. ■ Lilly quality control draws the line at ±0.0003 of an inch for some dimensions and ±0.0005 of an inch for others. A split hair can mean the difference between perfection and rejection . . . another of the many important controls that add immeasurably to the quality of the finished product.

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The JOURNAL
of the Florida Medical Association

The February Issue
Marion County Medical Society

Continuing a practice initiated in February 1963, The Journal presents this issue as a special number featuring contributions from a single county medical society. Members of the Marion County Medical Society have prepared the scientific articles and editorials this month and are to be commended for their excellent cooperation and the timely diversified material submitted.

We congratulate Dr. Henry L. Harrell, of Ocala, the guest editor for this issue, on the service he has graciously and competently rendered in obtaining the authors and sending in the articles on schedule.

To the contributors we express sincere appreciation. We are pleased to offer their efforts in this special issue as a challenge to the members of other county medical societies to share their scientific interests and editorial ability in like manner with the entire membership of the Association.

T.M.

The Marion County Medical Society now numbers 34. Although there has not been the tremendous increase in number of members that has occurred in other larger centers of the state, there has been a gradual increase and we can definitely state that our new members have contributed greatly to the quality and adequacy of the medical service to our community.

Although we are provincial and somewhat clannish and proud of our county society, we are not isolated. We boast one of the living ex-presidents of the Association, Dr. Eugene G. Peek Sr. His son, Dr. Eugene G. Peek Jr., is following in his father's footsteps by participating prominently in local and national medical statesmanship. In 1961 Dr. William H. Anderson Jr. was president of the Florida Society of Ophthalmology and Otolaryngology, and in 1960 Dr. Harry M. Edwards was president of the Florida Pediatric Society. Dr. Edwin H. Updike is the president-elect of the Florida Cancer Society, and it was my privilege to be president of the Florida Academy of General Practice in 1956. Several members have been and are current members of important state committees.

We are first of all proud of the quality of medical care we furnish our patients, and next we consider it a privilege to participate in all activities of our state Association.

Henry L. Harrell, M.D.
Guest Editor
Ocala

Arteriography in a Community Hospital

Alexander Goulard Jr., M.D.
Ocala

Refinements of technique of arterial radiography are accruing rapidly. Through trial and error my associates and I have tried, and are still trying, to develop the simplest, safest, and most economical techniques for extracardiac angiography that can be used at the small or medium size community hospital level.

Equipment

All the equipment that is essential is reasonable. One hundred to two hundred dollars will purchase all the catheters, needles, guide wires and catheter holders (ordinary ureteral catheter holders for storage and cold sterilization) required. As with many radiology departments we use radiopaque Odman catheters with internal diameters varying from 1.3 mm. (green) and 1.57 mm. (yellow) to 1.85 mm. (gray).** The basic mechanism for any percutaneous arterial catheterization is that the guide wire with its flexible tip in advance passes through the needle sheath, the needle sheath is then removed, and the tapered catheter, after being threaded over the guide wire, is advanced into the arterial lumen before the guide wire is removed. The catheter is the same size as the needle sheath and thereby plugs the hole in the artery.[1,2]

Other useful needles are Cournand for direct carotid arteriography, lumbar spinal needles for femoral arteriography and the 17 gauge Karras needle*** for brachial or axillary arteriography. The small Sedlinger guide wire for the green Odman catheter fits nicely in the Karras needle sheath. For some time, the items mentioned were all the equipment present in the community hospital, and for the most part adequate arterial studies were obtained, particularly single vessel brachycephalic injection and cerebral, femoral and renal artery studies. Before the use of a seriograph or pressure injector, we used the method of Poutasse[3] for renal artery studies modified to the extent of using a retrograde femoral catheter in place of direct aortic puncture. Retrograde catheterization has the advantage of accurate placement of the tip, relative freedom from pain, and complete control of bleeding. We used trimethaphan camphorsulfonate (Arfonad) to lower the blood pressure and obtain better filling of the renal vessels. This required the presence of either an internist or anesthesiologist, and when the blood pressure of an otherwise hypertensive patient suddenly fell below 100 mm. Hg systolic, the patient usually experienced nausea and anxiety, sometimes vertigo and vomiting.

As time passed, we obtained a seriograph. The most practical for our purposes is the Sanchez,† costing approximately $3,600. An Amplatz pressure injector was also obtained at a cost of approximately $1,000. While these are items of some expense, they are among the most reasonable of their type of equipment and not beyond the budgets of most community hospitals. The seriograph takes the guesswork out of where the bolus of dye is at any particular instant, and furthermore, since there is a time differential for the filling of the various vessels, the optimum filling of the vessel in question can be obtained without the overlapping of extraneous vessels seen with single long exposures (fig. 1). The pressure injector operates on CO_2 sparklet cartridges and develops an effective pressure of 930 P.S.I. with the 60 cc. syringe. A pressure of over 600 P.S.I. is never used and is not needed. The point of any injection is to deliver a bolus of about 20 to 25 cc. of dye in one second. Unfortunately, it cannot be done by hand injection with the size catheters used. While larger quantities of dye may be used in certain examinations as opposed to others, if the rate is maintained at approximately 20 cc./sec., arterial visualization will be good.

General Technique Considerations for Catheterization

We prefer to puncture and catheterize the largest vessel accessible for three reasons. (1) It is easier to puncture; (2) the larger the vessel the shorter the distance the catheter need be advanced; (3) there is less chance of dampening or occluding the peripheral pulse. For these reasons, all catheterizations are confined to either the femoral artery at the inguinal ligament or the axillary artery. The axillary artery is a particu-

From the Department of Radiology, Munroe Memorial Hospital, Ocala.

*Instruments and Catheters, Shick X-ray Co., 205 W. Wacker Drive, Chicago, Ill.

**Instruments, Nedmac, Inc., 5410 International Parkway, Minneapolis 27, Minn.

***Becton-Dickinson Co., Rutherford, N. J.

†General Electric, Schenectady, N. Y.



Fig. 1. — (a) A single three second exposure starting at about midinjection by hand pressure. Note overlapping of the superior mesenteric over the left renal artery; the splenic artery partly overlies the upper major branch of the left renal artery. (b) A 3/20 second exposure at the start of a high pressure injection shows differential filling of renal vessels before other vessels. Gravitation of the dye at least partly accounts for this. The renal arteries originate posteriorly from the aorta, and the patient is supine.

larly good artery to catheterize;[4] it is but a short distance from the arch of the aorta, has good collaterals and usually few arteriosclerotic changes, and as with the femoral artery direct pressure



Fig. 2. — Right axillary catheterization in the left posterior oblique view, one of three positions used for injection of arch vessels, with 50% Hypaque. Note how the catheter occludes the right vertebral artery. When it was pulled back, the vertebral artery was filled by hand injection.

can control bleeding (fig. 2). We have not seen even temporary obliteration of the peripheral pulse with catheterization of the axillary artery, while this does occur with brachial artery injections or catheterizations.

The technique of catheterization is as previously outlined. The only caution is never to force the guide wire into the vessel. It must ride free in and out of the vessel and needle sheath. If the guide wire is in any way damaged, throw it away. We prefer heparin, 1 mg. per cubic centimeter of normal saline, to fill and flush the catheter, with the total dose of heparin under 100 mg.; usually it is 30 mg. The catheter is advanced fluoroscopically with or without the guide wire extending to the tip of the catheter. If the guide wire is in place, an extension tube for flushing with heparin is used.[2]

As an alternate method to catheterization, the head and neck vessels may be examined by direct retrograde pressure injection through a needle in the brachial or axillary artery.[5] The advantages are that it is technically easier and is the preferred method to study the vertebral arteries both in the neck and intracerebrally, obtaining at the same time a right carotid artery study (fig. 3). The disadvantages are considerable recoil with



Fig. 3. — Direct injection of the left brachial artery. There are two areas of marked arteriosclerotic narrowing at the take-off of the subclavian artery (arrows), also some narrowing of the vertebral artery at the take-off. The patient had "subclavian steal" syndrome of vertigo with pain in the left arm, aggravated by raising the arm, and is now symptom-free after aortosubclavian bypass.

pressure injection through the stiff, single end hole needle with which we have had our share of subintimal injections (fig. 4) and the failure to visualize all four neck vessels with a single procedure. The best policy seems to be axillary catheterization for all four neck vessels and right brachial injection for intracerebral lesions combined with a left carotid artery study, as indicated clinically.

All arterial pressure injections are performed with the patient performing the Valsalva maneuver (respiratory straining against the closed glottis). In a hypertensive patient this may lower the systolic pressure as much as 50 mm. Hg, particularly if the injection is not made for five to 10 seconds after the start of the forced straining. The opaque medium used for all injections is 50% Hypaque or 60% Conray except for aortic arch studies where 75% Hypaque or 80% Angioconray is used. While some media may have advantages over others, we think the difference, particularly in the newer media, is not as important as catheter placement and radiographic technique.

Noncatheter Techniques

In the vast majority of cases angiography in any hospital, but particularly in a small one, is either cerebral or iliofemoral. The importance of renal artery studies, however, is gradually shifting this imbalance. The technique of cerebral angiography has long been standardized and consists simply of injecting one of the carotid or vertebral

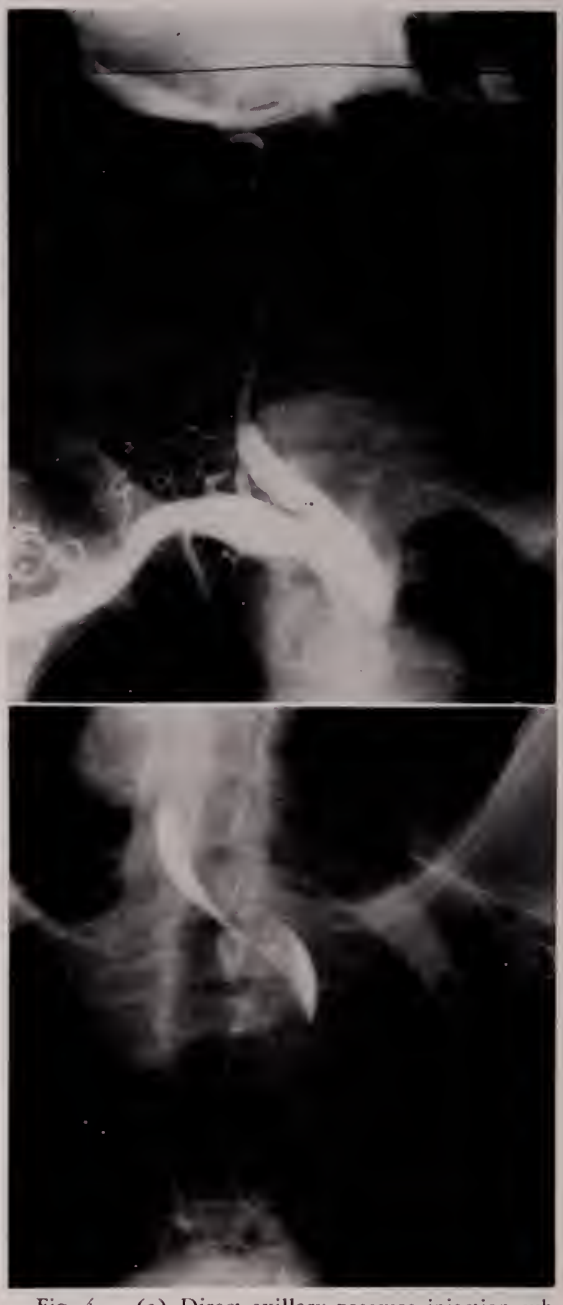


Fig. 4. — (a) Direct axillary pressure injection subintimally. A portion of the dye is intraluminal filling the vertebral artery; the remainder outlines the subintima of the innominate and carotid arteries. The delayed film (b) demonstrates the subintimal cast. The patient had pain of considerable degree and transient right hemiplegia and aphasia for two hours. The left internal carotid artery had previously been demonstrated to be completely occluded at the bifurcation and the left vertebral artery to be narrowed at its take-off from the subclavian artery.

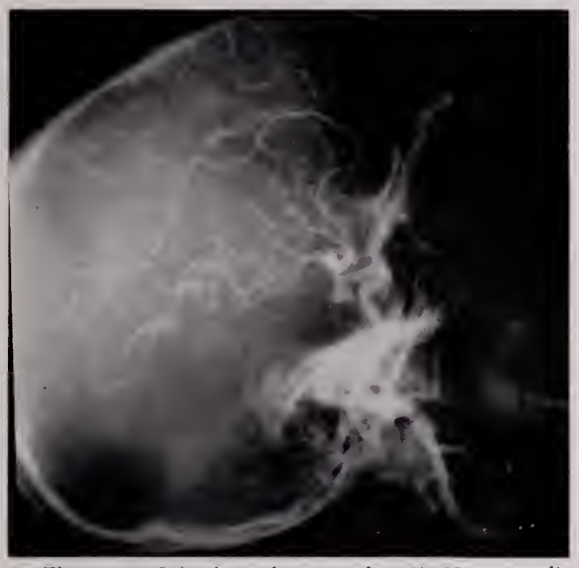


Fig. 5. — Injection of 8 cc. of 50% Hypaque directly into the left carotid artery demonstrates a lobulated aneurysm at the bifurcation of the internal carotid artery. At surgery elsewhere, two adjacent aneurysms were ligated at the junction of the posterior communicating and internal carotid atreries.

arteries with approximately 8 cc. of dye and obtaining serial or long exposure films of the intracerebral vessels (fig. 5). We prefer brachial or axillary artery approach to the vertebral arteries.

Femoral arteriography is performed by direct puncture of the artery below the inguinal ligament. Either a 14 by 36 inch cassette or two 14 by 17 inch cassettes, one with a grid and one in the Bucky tray, will cover the iliofemoral region to well below the knee. A two to three second exposure is used. An aluminum wedge filter is simple to make. One millimeter of aluminum over the thigh graded to 6 mm. of aluminum at the distal extremity (anode side of x-ray tube) has worked well.

If there is occlusion of the femoral artery, there may be a delay of seven to 10 seconds from the start of the injection to filling of the distal major vessel or collaterals below the knee. We have found it a distinct advantage to use a large quantity of dilute dye injected in 10 to 15 seconds; 25 cc. of 50% Hypaque or 60% Conray is diluted with saline to 50 cc. and a 10 second injection time is used. The three second exposure starts near the end of the injection. Dilution of the dye has the marked advantage of almost completely abolishing the pain of the injection and is the single most important step we have taken to improve our femoral arteriograms (fig. 6).

Either opposite retrograde femoral catheterization or direct aortography is performed for aortoiliac occlusive disease. We believe that the



Fig. 6. — Bilateral femoral arteriogram performed with diluted 50 per cent contrast material, half and half with normal saline, 50 cc. of solution on both sides with relatively slow hand injection. The film was exposed near the end of injection. Marked arteriosclerotic change but no major vessel obstruction was demonstrated.

patient should be selected carefully for aortography to the extent that the general condition is satisfactory to undergo aortoiliac surgery before direct aortic puncture is carried out.

Summary

With the advent of even simple arterial surgery such as occlusive disease of the extremity and with the developments in hypertensive renal artery disease, extracardiac arterial radiography must take its place at the local community level. Little equipment is needed, and it is suggested that the physician making the examinations not start out with complicated equipment such as a seriograph or pressure injector. As his interest, proficiency, and persistence progress, these technical advantages can be added along the way.

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Marion Medical Center.

Clinical Recognition of Hyponatremia

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Symptoms of hyponatremia are insidious, gradually worsen, then explode, often like a time bomb. They vary all the way from nausea and weakness to convulsions and coma. The cause often is not recognized immediately. This syndrome should therefore be considered in differential diagnosis with cerebral accident, diabetic coma, uremia, encephalitis, hepatic coma, heat stroke, and drug intoxications (barbiturate, alcohol, opium, bromide, or carbon monoxide).

Manifestations of hyponatremia suggest interference largely with function of the nervous system. They often are difficult to unravel from those of the primary illness itself, which is usually a malfunction of the heart, or the kidneys, or aldosterone secretion, or pituitary secretion, or the unknown mechanism seen in carcinoma of the lung.[1,2]

Malfunction of the brain in the presence of hyponatremia has been the subject of much study. Yannett[3] reported that the response of the brain to dilution of extracellular fluid is an exception to the general statement that cells imbibe water and swell under these conditions. From direct tissue analysis in experimentally induced hyponatremia he found that brain tissue did, in fact, lose potassium and that brain cells therefore may respond to dilution of extracellular fluids without net gain in intracellular water, and thus avoid swelling. Enclosed as the brain is within bony confines, this response is fortunate. A response by the brain similar to that of other tissues might result in a serious increase in pressure after a large ingestion of fluid.[3]

Although hyponatremia always indicates a relative excess of water over solute in the body, it occurs clinically under two different circumstances, namely (1) decreased extracellular volume, and (2) increased extracellular volume.

Decreased extracellular volume occurs when fluid and electrolyte are lost by vomiting, diarrhea, profuse sweating and other means, and fluid is replaced by water intake (with no electrolytes) either by mouth or intravenously. In this case the low plasma sodium concentration has developed an effective osmotic pressure which is soon balanced by movement of water into the cells to obtain equilibrium. The intracellular fluid volume is then high and the cells expanded, except in the brain as previously mentioned, with a shrunken extracellular fluid volume. Thus there occurs water intoxication in the cells, which is the chief danger of hyponatremia. Administration of water and 3 to 5 per cent sodium chloride intravenously is indicated, in divided doses eight to 12 hours apart.

With increased extracellular fluid, hyponatremia occurs when excessive fluids are given postoperatively because of an overestimation of the fluid needs, and 5 per cent glucose is given alone. Reduction of fluids and salt increase will rapidly correct this development when recognized early. In cases of cardiac decompensation, cirrhosis, or the nephrotic syndrome danger of hyponatremia also exists when edema is present. Restriction of fluids with normal salt intake is indicated. Infusions of hypertonic salt solution usually are contraindicated.

It is apparent, therefore, that the plasma sodium concentration alone gives no information relevant to the question of whether the body has an excess or a deficit of sodium. The extracellular fluid volume is the dominant factor in determining the body sodium equilibrium.[4]

Report of Cases

Case 1.—A man, aged 87, was seen in the office with weakness and shortness of breath on July 21, 1963. Rales were present over the chest and a two plus pitting edema in the lower extremities, with electrocardiographic changes compatible with left ventricular ischemia. Bendroflumethiazide with potassium chloride and Mercuhydrin, 1 cc., were prescribed.

He improved during the next three days. Mild mental confusion and extreme weakness then developed, and he was hospitalized. A convulsion and unconsciousness occurred on the fifth hospital day, at which time laboratory findings were: serum sodium, 130 mEq. per liter; serum chloride, 77 mEq. per liter; serum potassium, 4.2 mEq. per liter; blood urea nitrogen, 14.4 mg.; blood sugar, 114.0 mg.; hemoglobin, 14.7 Gm.; white blood cell count, 8,560; and hematocrit level, 46 per cent. The transaminase level was within normal limits on admission.

He remained comatose, but after a tracheostomy was performed and electrolytes brought into balance, he was out of bed in 12 days and at home after a total of 30 days' hospitalization. He continues well after one year on digitalis alone.

This case illustrates the unrecognized cause of the prodromal symptoms of mental confusion, interpreted as cerebral sclerosis in an 87 year old man in whom convulsions suddenly developed be-

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fore hyponatremia was considered. Correction resulted in full recovery.

Case 2. — A woman, aged 66, had been on hypertension therapy for years, taking hydrochlorothiazide with reserpine (Hydropres), 50 mg. once daily, and chlordiazepoxide hydrochloride (Librium), 5 mg. four times a day.

On Aug. 1, 1962, she complained of headache, weakness and dizziness, and was unable to do her housework. The blood pressure was 180/110 mm. Hg, and she was admitted to the hospital immediately.

The course in the hospital was unchanged until August 14, when she began to vomit, mental acuity decreased slowly, the headache became more severe in the occipital region, and she experienced extreme weakness. No localized neurological signs were noted, but she was very unstable on her feet.

At this point an electrolyte study revealed a serum sodium level of 133 mEq. per liter; serum chloride, 92 mEq. per liter; and serum potassium, 4.2 mEq. per liter. Convulsions developed before the hyponatremia was corrected. A blood sugar determination was 98 mg., and blood urea nitrogen, 7 mg. Intravenous pyelograms, urinalysis and blood culture gave negative evidence, a complete blood count was normal, and the cholesterol level was 232 mg. Eyeground examination gave negative results.

Correction of the hyponatremia resulted in complete recovery, and now, one year later, the patient remains well.

In this case the prodromal symptoms gave a strong impression of hypertensive encephalopathy that postponed further differential diagnosis. This case also illustrates that the amount of extracellular hyponatremia, as judged by laboratory determination, is not in direct proportion to the severity of symptoms. It is the extracellular fluid volume that is the dominant factor.[4]

Case 3. — A man, aged 54, had been taking dexamethasone (Decadron) for emphysema for three years, averaging two tablets a week until the last six months, when he, himself, increased the medication to one to three tablets daily for control of gouty arthritis.

On June 22, 1962, he was hospitalized with fever and malaise. Pneumonitis was confirmed by x-ray and controlled in one week. He remained, however, with no appetite, some nausea, and a full feeling in the abdomen. By the fourteenth hospital day his condition had worsened, and he was withdrawn, depressed and uninterested in his surroundings. He had pain in the bladder after voiding. Dexamethasone had been continued at one to one-half tablet a day, and polythiazide (Renese), 2 mg. daily, was added on admission.

On July 4, the electrolytes were determined to be: serum sodium, 110 mEq. per liter; serum chloride, 54 mEq. per liter; serum potassium, 2.1 mEq. per liter and CO_2 combining power, 30 mEq. per liter.

Other findings were: rheumatoid arthritis test, weakly reactive; total blood protein, 6.0 Gm.; uric acid, 9.7 mg., and upper gastrointestinal series, urinalysis and complete blood count normal. Urological consultation and surgical consultation on the abdomen yielded no evidence of disease. The patient was discharged recovered on July 14, 1962.

The mental symptoms here were overshadowed by the abdominal complaints, particularly distention and pain in the bladder; also, it is remarkable that no convulsions occurred although the hyponatremia by laboratory determination was severe. This case again demonstrates that the amount of extracellular fluid is the dominant factor and must be determined on clinical grounds alone.

Case 4. — In a woman, aged 83, with an intertrochanteric fracture treated by body cast, pyuria developed on Sept. 14, 1958, while she was in the hospital. Sensitivity tests indicated the proper drug to be nitrofurantoin (Furadantin), which had to be given intravenously after October 1 because of gastric irritation; also, 1,000 cc. of 5 per cent glucose was given in this manner daily.

Lethargy gradually developed, and in 10 days, after much nausea and vomiting, and increased intravenous fluids, she was unresponsive and vomited any type of oral intake. An electrolyte study on October 10 revealed a serum sodium level of 113 mEq. per liter; serum chloride, 92.5 mEq. per liter; and serum potassium, 2.6 mEq. per liter. The patient recovered after correction of the electrolytes and was out of bed in a chair by October 21.

This case illustrates the hyponatremia that occurs by dilution, accompanied by potassium washout.

Case 5. — A woman, aged 87, had been receiving digitalis and a weekly dose of mercurial diuretic for four years. Mental confusion developed and her condition gradually worsened over a four day period until she was admitted to the hospital on Nov. 27, 1959. At this time she appeared moribund and could scarcely answer questions with an unintelligible mumble. On admission, the serum sodium was 110 mEq. per liter; serum chloride, 95 mEq. per liter, and serum potassium, 4.3 mEq. per liter, with a normal blood urea nitrogen determination and complete blood count. The urine had a trace of albumin and contained many red cells and white cells. There was an enlargement of the liver to three fingerbreadths below the costal cage, but no pretibial edema was present.

Correction of the sodium balance resulted in complete recovery after a stormy three weeks of diarrhea. The patient was discharged on Jan. 2, 1960. Two and one-half years later she succumbed to pneumonia.

This case, believed to be one of cerebral accident when the patient was admitted, illustrates the confusing picture that is presented in low sodium syndrome. A surprising finding throughout the stormy recovery was the persistent normal potassium level.

Comment

These experiences show that the milder symptoms are anorexia, headache, apathy, weakness, nausea, vomiting and mental confusion. The severe symptoms are convulsion and various stages of coma.

The whole subject of fluid and electrolyte balance is complicated.[5,6] It is necessarily so in order to keep 42 quarts of water and 15 heaping teaspoonfuls of salt containing more than a dozen different electrolytes and hormones working together in perfect harmony during a normal lifetime, with infinitely wide variation in intake and loss of both water and electrolytes. This struggle for balance is further compounded by the modern use of diuretics, hormones, and intravenous fluids in general daily practice.

When convulsions and coma are present, the patient may be needlessly subjected to spinal puncture and harmful intravenous fluids unless the serum sodium concentration is considered. One should always remember that clinically this laboratory determination must be related to the dominant factor of the extracellular fluid volume.

Summary

The syndrome of hyponatremia should be added to the list of probabilities in cases that present mental manifestations and prostration.

The need for unraveling this syndrome from the underlying condition is not always apparent unless the clinician is fully oriented on the wide range of symptoms. In one case in this series hyponatremia was not recognized during 14 days of observation, although the patient was seen by more than one consultant.

The exact mechanism of the mental symptoms has not been fully explored,[4] but is possibly a depletion of the potassium in the brain cells,[3] in the body's struggle to maintain osmotic equilibrium without cellular swelling within the bony confines of the brain.

Appreciation is expressed to the staff of the Medical Service of Munroe Memorial Hospital for the privilege of reporting cases 2, 3 and 4 in this series; also to the University of Florida College of Medicine for the library and bibliography services.

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Cavernous Sinus Thrombosis

Report of Case

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Cavernous sinus thrombosis produces pathognomonic physical signs by inspection and should be familiar to all physicians, although it is an uncommon disease in this antibiotic era. Those features usually present are: generalized sepsis; venous obstruction of the retina, conjunctivae, and eyelids; paresis of cranial nerves III, IV, and VI; proptosis; and meningeal irritation.[1] Sources of infection producing the septic thrombosis are structures of the face, mouth, ears, and mastoids. Shaw[2] listed the initial focus as facial furuncle in 61 per cent, sinusitis in 15 per cent, otitis in 8 per cent, infections of the teeth in 7 per cent, facial erysipelas in 5 per cent, other infections of the mouth in 2 per cent, and unknown in 2 per cent. Nearly always fatal prior to antibiotics, this disease now has a relatively good prognosis if treated early and vigorously. The institution of antibiotic therapy should not await the results of bacteriologic studies. Since the causative organism is usually a gram-positive species, Brown[3] recommended therapy with penicillin G., sodium methicilin (Staphcillin) and streptomycin. The use of anticoagulants has been somewhat controversial.[4]

Report of Case

A 51 year old white married house painter complained of diplopia with objects side by side and left frontal and temporal headaches experienced about May 22 or 23, 1963. These symptoms were of fairly acute onset and accompanied by chills. A week later he noticed swelling of the left eye and redness in the eye. At this time he consulted a physician and was treated with antibiotics, and skull x-rays were taken. The symptoms persisted. The patient was referred to one of us (W.B.) for further evaluation, at which time the impression of cavernous sinus thrombosis was made.

There was a past medical history of chronic recurrent purulent nasal discharge with large crusts. No definite history of ear or mastoid infection was elicited. The patient admitted to having recurrent sinus headaches in the past, but not in the last few months. He was struck in the left posterior part of the head when he was 11 years old, apparently suffering a skull fracture at that time. A systems review was nonrevealing except that the patient had "chest congestion" with pleurisy two years ago.

On physical examination, the patient was a well developed, well nourished middle-aged man who complained of severe left-sided headaches and had a striking proptosis

and fixation of the left eye with marked edema and chemosis on the left side of the face. The pupils were normal with slight dilatation of retinal venules on the left. There were typical findings of atrophic rhinitis and large crusts with some mucopus. This was cultured. Irrigation of the maxillary sinuses was clear. Approximately one third of the teeth were missing. The head and neck otherwise were normal. Neurological examination was unrevealing except for the fixation of the left eye. There was no nuchal rigidity.

Examination of the spinal fluid including culture gave negative results. The white blood cell count was 10,000 on admission with a differential count of segmented forms 55, lymphocytes 23, monocytes 7, and eosinophils 15. On discharge, the white blood cell count was 5,000 with a normal differential. Skull x-rays were normal, and the sinuses were interpreted as showing chronic pansinusitis.

Course in the Hospital.—The patient was given antibiotic therapy consisting of 20 million units of penicillin daily by continuous intravenous infusion and 2 Gm. of streptomycin intramuscularly daily; three days later, after results of the nose culture showed pseudomonas organisms, the patient also received chloramphenicol (Chloromycetin), 500 mg. every six hours by mouth, and Coly-Mycin, 50 mg. every six hours intramuscularly. At the time of hospitalization he was given anticoagulant therapy with heparin, which was later changed to warfarin sodium (Coumadin). Four days after admission on June 11, 1963, less edema of the conjunctiva of the left eye was noted, but some early edema of the conjunctiva of the right eye was present. The headache persisted. By June 17, there was more edema of the conjunctiva of the right eye, but less edema of the conjunctiva of the left eye, and by this time there was also paralysis of the right superior and inferior rectus and oblique muscles. There was return of function of the left superior and inferior recti but paralysis of the lateral and medial rectus muscles on the left. The headache had subsided by June 18. By June 25, edema of the conjunctiva had virtually subsided in both eyes, although there was still mild bilateral proptosis. Extraocular movements were unchanged except for return of function of the inferior rectus on the right side. By June 31, there was some function of the left literal and medial recti. There appeared to be slight blurring of the disk margins in the left eye. By July 4, there was less proptosis, and some slight improvement was noted in all extraocular movements. Improvement continued until the patient was discharged from the hospital on July 13.

On August 1, he appeared to have full recovery of extraocular movements on the right, but paresis of the left medial rectus and slight diplopia on distant vision. There was complete return to normal on September 3, except for minimal diplopia.

Discussion

Since the patient had been receiving antibiotics prior to cultures, we are uncertain as to the etiologic organism. Pseudomonas organisms were, however, cultured from the nose, and since it was believed they could be a pathogen, appropriate antibiotics were used against these organisms in addition to utilization of penicillin and streptomycin in large doses. Treatment was continued empirically for six weeks. The source of the infection in this patient was the sinuses. Clinically striking features were absence of fever recorded at any time and the persistent eosinophilia (up to 20 per cent). Brown[3] suggested the distinct possibility of adrenal insufficiency due to involvement of the hypophysis, and one of his patients suffered acute vascular collapse. Our patient manifested no overt clinical signs of adrenal insufficiency.

Summary

A case of cavernous sinus thrombosis is presented. The patient was treated with antibiotics and anticoagulants over a period of six weeks, and at present his recovery is almost complete.

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Marion Medical Center.

New products are always significant but many older ones of real value have weathered the trend toward the "new." One of the real standbys in the treatment of epilepsy, and one in use since 1938, is DIPHENYLHYDANTOIN. (See advertisement of Parke, Davis & Co., inside front cover.)

The brief notes on the drug preparations featured in the advertising section of this issue of The Journal were prepared by Mr. B. S. Rogers of Jacksonville, representing the Florida State Pharmaceutical Association. Mr. Rogers is also president of the American College of Apothecaries. We are grateful to Mr. Rogers for this assistance and for additional notes which will appear in each issue during the year.

Renal Papillary Necrosis

Report of Case

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Necrotizing papillitis of the kidney, originally described by Friedreich[1] in 1877, has since become both a pathological and clinical entity. The pathogenesis has been a much debated issue.[2] Explanation of the ischemic necrosis has met with difficulty because of the peculiar medullary blood supply (fig. 1). The potential shunting of blood between the arcuate artery and the juxtamedullary glomerular efferent arterioles, and potential spastic ischemia of the papillary regions are plausible explanations.

The lesion is most often, but not always, associated with acute and chronic pyelonephritis. It is especially common in patients with diabetes and associated pyelonephritis. Obstruction of the urinary tract is regarded as a predisposing factor. Chronic overdosage of phenacetin has been reported as a contributing factor during the past decade.[3,4,5,6,7]

Clinical Course

The clinical features of renal papillary necrosis consist of intensified symptoms of pre-existing pyelonephritis: fever, lumbar pain associated with colicky ureteral radiation and hematuria. The urinary sediment on microscopy will show white blood cells with clumping, occasional red blood cells and casts. There may be migrating sloughs of renal papillae. Pyelography may reveal scarring, asymmetry of chronic pyelonephritis, cavities and sinuses in the region of the papillae.

This disease should always be considered in the differential diagnosis when elderly patients with diabetes are showing rapid deterioration in clinical status and signs of active pyelonephritis with increasing renal decompensation. It should also be looked for in urinary obstructive diseases, severe systemic infections and chronic vascular diseases. The prognosis, though not invariably fatal, is serious. The disease may be aborted by treatment of the causative source, such as bacterial, obstructive or toxic, and so warrants early recognition.

Report of Case

A Caucasian woman, aged 44 years, was first examined by her local medical physician in November 1962 complaining of sudden onset of severe pain in the left flank and red urine, three weeks prior to her visit. Marked pyuria was noted on urinalysis and an intravenous pyelogram revealed a nonfunctioning left kidney. The patient showed no response to medication and was referred to a urologist, at which time a retrograde pyelogram revealed normal findings.

A repeat intravenous pyelogram in January 1963 revealed evidence of only slight function in the left kidney. The patient was advised to have a nephrectomy, which she refused. She was treated with various antibiotics to no avail, and a subsequent intravenous and retrograde pyelogram revealed a shrunken (one-third normal size) left kidney, with evidence of somewhat improved function. The infection, however, had not cleared. In May 1963 she was hospitalized with the complaint of severe abdominal pain in the right lower quadrant. Bilateral renal urine specimens revealed pyuria.

The personal history indicated a rectal fistulectomy in 1944 and a hysterectomy in 1952. The patient had two normal pregnancies, the last delivered 18 years ago. She had a 24 pound weight loss in the past six months and suffered from frequent headaches and epigastric burning, sometimes provoked and sometimes relieved by food.

The family history revealed a 76 year old mother with diabetes, the father deceased at 68 years following a "stroke," and five siblings with no contributory history.

On May 12, 1963 the patient was admitted to the hospital for evaluation and surgery. Physical examination revealed: temperature, 99 F.; pulse rate, 104 beats per minute, strong and regular; respirations, 16 per minute; and blood pressure, 152/98 mm. Hg. Examination of the heart and lungs, including chest x-ray, was not remarkable. At the costovertebral angle tenderness was noted bilaterally.

Laboratory studies revealed: hemoglobin 13.4 Gm. per hundred milliliters; hematocrit reading, 39.5 vol. per cent; white blood cell count 9,650 with segmented neutrophil forms 60, lymphocytes 33, monocytes 1 and eosinophils 6 per 100 white blood cells counted. Erythrocytes were unremarkable and platelets appeared adequate on peripheral blood smear. Urinalysis revealed: slightly cloudy urine with specific gravity 1.004 and pH 7, albumin 1 plus, sugar and acetone negative. Microscopy of the urinary sediment revealed many epithelial cells and numerous white blood cells per high power field with clumping. The blood urea nitrogen was 7.15 mg. per hundred millilters.

The surgical specimen consisted of a left kidney weighing 110 Gm. and measuring 9.5 by 5.5 by 3.5 cm. The capsule stripped with ease revealing a finely granular, lobulated, tan to mottled red-violet, shiny subcapsular surface. The cut surface revealed a well defined corticomedullary differentiation. The cortex was injected and measured up to 0.6 cm. in width. Within the calyces, there were soft, black fragments of tissue partially adherent to the renal medullary papillae. There were finely granular, red to tan cavernous spaces measuring up to 0.5 cm. in diameter. The mucosa of the renal pelvis was white to tan, finely granular and shiny.

Microscopic examination revealed broad areas of inflammatory round cells (lymphocytes and plasma cells) extending from the subcapsular surface to the medulla. There was a slight increase of medullary fibrous stroma. The glomeruli were prominent and engorged, as were the intrinsic blood vessels of the cortex, with sharp definition of the corticomedullary junction. The inflammatory component of the renal papillae converted to polymorphonuclear leukocytic infiltrate (fig. 2). The proximal convo-

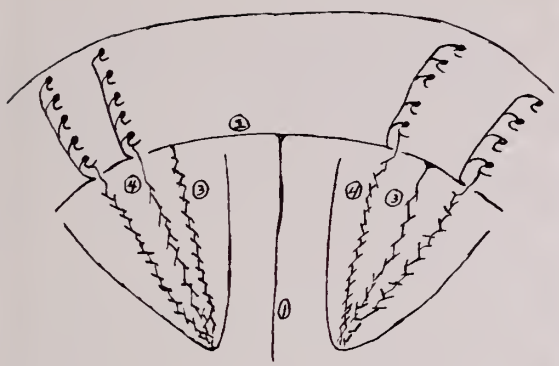


Fig. 1. — (1) Interlobar artery; (2) Arcuate artery; (3) Arteriolae verae rectae; (4) Arteriolae vasa rectae. Diagram.

luted tubules and descending loops of Henle showed cloudy swelling of the lining cells. Some of these tubules were dilated and contained fibrillar to amorphous eosinophilic material (fig. 3). The ascending loops of Henle, distal convoluted tubules and collecting tubules were dilated, showing vacuolization of the lining cells and containing amorphous eosinophilic material (fig. 3). The mucosal lining of the renal papillae was patchy with foci of denudation and replacement of the cellular components by outlining fibrous stroma (figs. 2 and 4).

The pathological diagnosis was severe chronic pyelonephritis with acute exacerbation and necrotizing papillitis.

The patient was discharged on the eighth postoperative day. She continued treatment on an outpatient basis with chloramphenicol (Chloromycetin) and nitrofuratoin (Furadantin) for one week, followed by long term urinary antibacterial (Mandelamine) treatment. Improvement was slow but progressive.

Comment

In most instances chronic pyelonephritis precedes the episode(s) of renal papillary necrosis both clinically and pathologically. One of the alerting features of the disease is the increasing severity of clinical symptoms and signs of pyelonephritis. The patient with diabetes who is prone to infection and vascular disease should always bring to mind the possible diagnosis of renal papillary necrosis in the face of worsening pyelonephritic symptoms. As is the rule in differential diagnoses, entertaining the possibility of a diagnosis is the first step in making the diagnosis and, conversely, "out-of-mind, out-of-a-diagnosis."

The circulatory aspect of renal papillary necrosis, if it is of ischemic nature, readily reminds one of the peculiar regional circulation of the papillae —in fact, so peculiar that it is one of the few anatomical controversies of "modern anatomy." In patients with and without diabetes mellitus showing severe chronic pyelonephritis, one of the primary lesions, if not the primary lesion, is renal vascular pathology. The Kimmelstiel-Wilson syndrome (diabetic glomerulosclerosis) is not discussed herein. The lesion involves the capillary walls



Fig. 2. — Sloughed necrotic papilla with clear space ghost remnants of collecting tubules (left). Polymorphonuclear leukocytic infiltrate and denuded mucosal lining of renal papilla. Increased fibrous stroma of medulla with vacuolization and dilation of collecting tubules (low center). Mag. X 100.8.

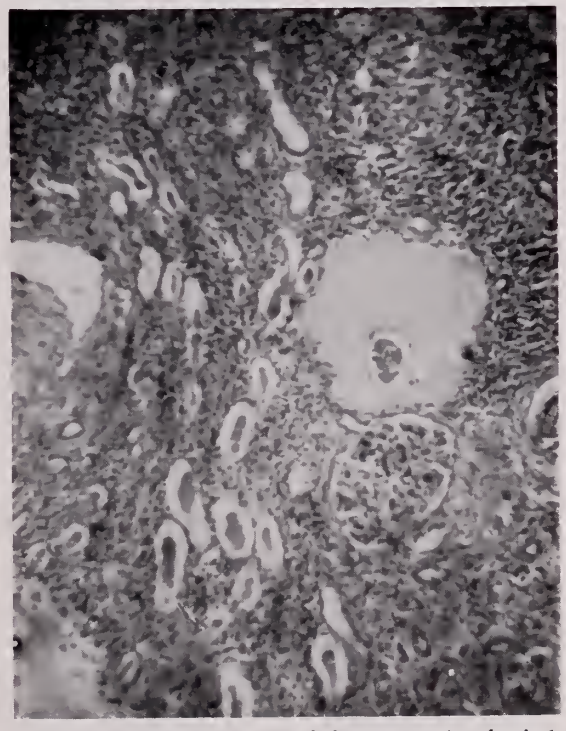


Fig. 3. — Markedly dilated distal convoluted tubule (center), dilated Henle loops and collecting tubules with amorphous material ("thyroidization"). Marked round cell inflammatory infiltrate and engorged prominent glomeruli with sharp delineation of the corticomedullary junction (lower left). Mag. X 100.8.



Fig. 4. — Arrow indicates necrotic papilla within the calyceal space. Scattered collecting tubules of medulla are dilated. Papilla with areas devoid of mucosa and increased fibrous stroma (lower right). Mag. X 25.

of the glomeruli and does not pertain to the papillary necrosis. This disease entity warrants discussion beyond the scope of this paper. The concurrent presence, however, of diabetes mellitus, chronic pyelonephritis, Kimmelstiel-Wilson disease and renal papillary necrosis must not be brushed aside unnoticed. Polyarteritis nodosa is another precursor to renal papillary necrosis.

With the advent of recent publications of cases pertaining to phenacetin and its relation (chronic overdose usage) to renal papillary necrosis, a confusing term, particularly to the clinician, has come to the fore, namely interstitial nephritis without the very necessary adjectives: acute diffuse, acute focal or chronic.

If the term "acute diffuse" is referred to, the glomeruli and tubules are relatively unaffected and the disease entity is strictly a mononuclear inflammatory infiltration involving the interstitial substance. Though very severe forms may provoke acute renal shutdown, this is not the usual course of events. Impairment is as a rule mild to moderate, clinically characterized by albuminuria with little or no azotemia. This, however, does not say that phenacetin is not related to the cases of renal papillary necrosis reported.

The "acute focal" lesion is restricted to the corticomedullary junction or medulla. It is characterized by mononuclear infiltrate and attributed to focal reaction from drug and other toxic stimuli.

If the adjective "chronic" is referred to, then this is none other than the disease entity presently grouped under the title of chronic pyelonephritis. The morphological pattern is that of chronic pyelonephritis involving the tubules, glomeruli and scarification.

Diagnosis of renal papillary necrosis is made on the basis of: progressive increasing severity of chronic pyelonephritis symptomatology; finding ghost remnants of sloughed renal papillary tissue in the urinary sediment, either on routine urinary sediment microscopy or "Pap smears" of urinary sediment while ruling out the presence of malignant disease; x-ray evidence in the retrograde and intravenous pyelogram of scarring, asymmetry of renal pattern and evidence of cavities and sinuses in the papillary regions.

Summary

A brief history and discussion of the disease entity renal papillary necrosis is presented in conjunction with a case report. Discussion includes possible pathogeneses, clinical course of the disease, principal diagnostic measures and pathology.

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1812 Edwards Road.

Six out of 10 persons have troubled views of the future, according to one study. This could be one reason why the drug, CHLORDIAZEPOXIDE, has become so popular. The easy to remember trade name of this drug is listed on the back cover advertisement of Roche Laboratories.

Intensive Care Unit
A Practical Plan
for the Community Hospital

Edwin H. Updike, M.D.
Ocala

Munroe Memorial Hospital is a modern completely air-conditioned 155 bed general hospital. It is the only hospital in Ocala, is supported by both the city and county, and is truly the community hospital for about 60,000 people. Our intensive care unit has been in operation two years.

The initial stimulus that resulted in our intensive care unit was the necessity for providing proper postoperative nursing for an increasing number of patients subjected to elective thoracic operations. We found it difficult to provide adequately experienced special duty nurses, especially at night. A committee from the medical, nursing, and administrative staffs studied the problem and visited intensive care units in operation in Sarasota and Jacksonville. After careful planning and briefing of the hospital staffs the unit was opened Oct. 1, 1961. The results have been so gratifying that it seemed worth while to document our experience so that other community hospitals, presumably faced with similar problems, might be encouraged to develop similar units.

Plan of the Unit

A combined medical-surgical unit seemed most likely to suit our needs. The best available space was a four bed ward near the operating and recovery rooms. This ward was already equipped with lights, wall oxygen and electric outlets, and curtains for four beds, and had a lavatory and sink. We made minor alterations, connecting through to an adjacent storage area to provide accessibility, and installed a central nurses desk, phone, cabinets and icebox. Space was limited, and the narrow, large-wheeled recovery room beds which were purchased have proved durable and efficient. Wall sphygmomanometers were installed for each bed and a piece of aluminum pipe suspended from the ceiling, transverse to the long axis of the beds at about their midpoint. This pipe provides a convenient way to suspend multiple intravenous solution bottles and have them out of the way. The cost of these alterations was about $850.

In order to have instantly available service for both patient and doctor the room was equipped and supplied so that it is not necessary to go to central supply except to replenish the unit supply. Intravenous infusion equipment, tracheotomy trays, aspirating suction machines, thoracotomy and gastrointestinal negative pressure suction machines, intermittent positive pressure breathing apparatus, nebulizers, and all commonly used and emergency injectable and intravenous medications are kept on hand. The cost of this equipment was about $3,000.

Unit Staff and Cost

The unit is staffed around the clock with an experienced registered nurse and an aide, except when the unit is empty. When there is only one patient, the aide is kept busy but available on a nearby floor. The patient is constantly tended despite staff requirements for meals, coffee breaks, et cetera. Staff hours and salary costs are shown in table 1 for a recent three month period (July-September 1963), which is average for the last year or more. An average census of 2.49 brings in enough revenue at our rate of $35 per day to pay the salary cost plus an allowance for overhead and depreciation. This is economical for the patient as it is less than half the daily cost of a semi-private room plus round the clock private duty nurses and rental of similar equipment.

Type of Patient and Results

A typical three month period (October-December 1962) was analyzed. A total of 66 patients (34 female and 32 male) was treated in the unit for an average of 3.3 days. The average hospital stay of these patients was 15.6 days. There were 20 medical patients and 46 surgical patients, of whom seven were trauma victims. Table 2 lists the reasons for admission to the unit.

Fifty-one of the patients recovered and 15 died. Table 3 lists the diagnosis in the fatal cases.

Table 1. — Average Monthly Cost of Staffing Intensive Care Unit

July-September 1963

Total nursing shifts per month	92
Shifts staffed with registered nurses	90
Shifts staffed with aides	77.50
Daily average patient census	2.49
Patient days of service per month	76.70
Revenue (days of service times $35)	$2,683.00
Salary expense	$2,100.00

Table 2. — Reasons for Admission to Intensive Care Unit

October-December 1962

Surgical		46
Multiple injury	4	
Major abdominal trauma	2	
Major abdominal elective surgery	28	
Thoracic surgery	4	
Obstetrical operation	1	
Miscellaneous surgery	7	
Medical		20
Myocardial infarction	5	
Cerebrovascular accident	3	
Congestive heart failure	4	
Overdose of sedatives	2	
Miscellaneous	6	
Total		66

Table 3. — Diagnosis in Patients Who Received Intensive Care and Died

Cardiovascular disease	9	
Metastatic carcinoma	3	
Postoperative transurethral prostatic resection, uremia	1	
Intestinal obstruction, uremia	1	
Trauma, multiple injury	1	
Total		15

The average age of these patients was 61.3 years with a range of three to 101 years.

Benefits of the Unit

1. The care of the most critically ill is concentrated in the hands of a few nurses who have a continuing experience with this type of case. They become more acutely aware of subtle but significant changes in the patients' condition and with increasing familiarity with the principles and practice of intensive care are able to institute remedial measures rapidly and effectively, sometimes even before the attending physician can be obtained. These nurses develop a confidence in their care that was frequently lacking in the private special duty nurse who was often unfamiliar with the type of case and apprehensive lest she do something wrong. This confidence born of experience is definitely a plus factor in the recovery of the patient as well as a reassurance to the family and physician.

2. The care is economical. As outlined, this is better care for half the cost.

3. The intensive care is available 24 hours a day, on a moment's notice most of the time, and this is especially useful for postanesthetic recovery after regular operating hours.

4. The concentration of critically ill time-consuming patients in one area improves the general hospital care by allowing the regular floor nurses more time for the other patients.

5. The instant availability of supplies, equipment, and assistance enables the physician to use his time to the best advantage in caring for the critically ill patient.

Problems

We really have had no major problems other than being somewhat cramped. Relatives have objected very little to the limited visiting hours (one visitor for five minutes once an hour), perhaps partly because their waiting area is nearby and we make a conscientious effort to keep them informed. Physicians have cooperated fully when questions regarding which patients most needed intensive care came up, and we have not had to ask the service chiefs to settle any such problems.

Summary

For two years we have operated a four bed combined medical-surgical intensive care unit. An average of 22 patients per month spent 3.3 days in the unit out of 15.6 days in the hospital. The $35 daily charge covered the expenses with the unit 62.2 per cent occupied. This cost is approximately half the cost of similar care in a semi-private room with private special duty nurses. In addition to the economy, the patient benefits from more experienced nursing care, the hospital benefits from the increased nurses' time available on the floors for the other patients, and the physician can more rapidly and effectively do his work for the critically ill. There is increased confidence on the part of all concerned in the quality of the care provided. No serious problems have been encountered.

Appreciation is expressed to Mr. Ben P. Wilson, Superintendent of Munroe Memorial Hospital, Ocala, for providing the nursing time and cost analysis.

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President's Page

Home Work

Gone is the day when our youngsters were able to do all their work at the schoolhouse. The schedule is so full and the curriculum so exacting that some of their responsibilities must be fulfilled after the regular hours and at night. Similarly, the modern physician, as a leader in society cannot leave his office at five in the afternoon feeling that he has measured up to his duties as a professional man and as a citizen. There are certain pressures in contemporary life which necessitate an extra effort. Let us consider for a few moments some of these added duties, which may be classified as home work.

Tremendous advances in the media of communications during recent years have definitely influenced attitudes of people toward the medical profession. Radio, motion pictures and television have brought to the general public much medical information of a technical character. This has been broadened in scope and distribution by articles published in national magazines, designed primarily for reading by laymen. These publications include the Reader's Digest, Time and Life. Members of the medical profession have been inclined to discount the value of this information and, on occasion, have thought that it was misinformation. But we must be realistic about the results. No longer is the physician considered the sole arbiter and judge in matters pertaining to the public health. One of our responsibilities includes detailed and objective evaluation of this material in the light of medical advances, and interpretation of progress resulting from the achievements of research. The average patient is unable, with his limited scientific background, to arrive at an intelligent opinion. But he is impressed, and it is strictly up to the doctor.

We also have responsibilities to each other. Attendance at the regular meetings of our county medical societies has not been good for the past few years. This is understandable, but not justifiable. The component county society is the unit upon which our entire state organization is built. The success of the latter depends upon the enthusiasm and active interest of the former. It requires an extra effort and greater self discipline to attend. But more general and active participation in county medical society affairs by our members will produce a happier and better informed state organization. A few dedicated and loyal members are now carrying the responsibilities and doing the work of many. And they are sometimes called medical politicians. Various gimmicks have been attempted to improve the attendance record. One of the most successful methods, adopted by a few larger societies in urban centers, combines a few of the quarterly hospital staff meetings, a social hour and dinner with the regular monthly business and scientific programs, on the same afternoon and evening. Other societies are trying to impose a compulsory attendance at one out of four regular meetings, despite the fact that doctors resent compulsion in any form. The answer must come from increased enthusiasm, more interesting programs, and a desire to do the job well.

With this responsibility for regular attendance, there are certain rights and privileges associated with membership in the county society. Fringe benefits include participation in certain types of group insurance which would not be available to us as individuals. Life, retirement, professional liability, health and accident and major medical protection is obtainable at reasonable rates. Ethical problems or professional difficulties are reviewed and judged by a jury of our peers, who are medically trained, and not a group of laymen. In addition, there is the fine privilege of friendship and association with a group of wonderful people who have the same background, interests and motivation as we.

Our profession is the target of many groups who are anxious to utilize our talents. To combat their harassments requires time, imagination and effort. We value our freedom to practice as individuals. And we speak of the profession as a private enterprise. Yet we are surrounded by restrictions, many of which are essential.

As members of the Florida Medical Association our responsibilities to the medical profession, to each other and to our patients demand extra effort and greater awareness. Some of the needs demanding our help are not primarily medical, but may be educational, political or civic in origin. Let us do our home work well. Thus, the image of the physician will be presented in its proper perspective, and not distorted.

Everyone is grateful to those who are serving the Association well. But this is a plea to the others, who are willing and satisfied to "let George do it." Anatomy, pathology and physiology are basic. But here are things that also are important, and they are not in the books.

Warren W Quillian



Editorials

Medicine—An Art as Well as a Science

"Medicine is not only a science; it is also an art." "The practice of medicine is an art, based on science." "The tendency is for the science of medicine to obscure the art. If the proper perspectives are maintained, they supplement each other. One would not belittle scientific advances in medicine, but they are most fruitful if applied when the art of medicine has laid the foundation in the quest for the solution of a clinical problem."

These three quotations are taken from Paracelsus, Sir William Osler and Garfield G. Duncan, early sixteenth, nineteenth and twentieth century clinicians, famous for bedside instruction methods as an instrument of medical tutelage, among other things. In the latter half of the twentieth century, scientific advances have made tremendous strides. Camouflage, however, obscuring the art of medicine, seems to be in the making. To substitute protein-bound iodine determination (radioactive and chemical), butanol-extractable iodine, radioactive iodine thyroid uptake (count and scanning), radioactive triiodothyronine uptake (erythrocyte and serum) for Robert J. Graves' very complete clinical description of thyroid disease is an inexcusable injustice to the patient and everyone else concerned. This is not to belittle our scientific advances, but to alert the clinicians to be selective about test procedures warranted for confirmation of their "prior-to" entertained differential diagnoses, or progress of the disease in question. It is in this sense that the available broad spectrum of test procedures can best serve the clinician and his patient.

We have, in every hospital today "routine procedures," such as complete blood count, urinalysis, serology and others, depending upon the hospital and the department involved. It is the clinician's discretion that prevents liver profile, renal profile, gallbladder series, upper and lower gastrointestinal series, ad infinitum, from becoming routine procedures. We are aware of the value of these test procedures, and physicians use these tests when clinical acumen indicates the need.

In medical school and postgraduate training, routine test procedures are set up for pattern and memorization to avoid omission of pertinent data.

It is a known fact that interns just out of training have a tendency to order batteries of tests as a reflex habit. This is a carry-over from requirements and availability of tests during the training period, which is not easily overcome once they are in private practice. One of the alerting signals for the neoclinician is the fact that some of his patients, with restricted income, cannot afford extraneous test-procedure expenses. Thus the request for tests can become limited to the bare essentials necessary to confirm the groundwork laid by the art of clinical investigation, namely a thorough history and physical examination, taxing to the maximum the utilization of four of our senses, sight, hearing, smell and touch.

There is much to be acquired through scientific investigation with improvement of laboratory test techniques and development of new tests: true blood sugar versus blood sugar (reducing substances); serum cholesterol determinations (various modifications of the Liebermann-Burchardt reaction); hemoglobin determination (carboxyhemoglobin, cyanmethemoglobin, and oxyhemoglobin methods); electrophoretic and paper chromatography techniques for serum proteins, lipids, hemoglobins, all for the purpose of aiding in the understanding, diagnosing and treating of existing diseases as well as uncovering yet unrecognized diseases.

One of our setbacks in selection of test procedures is the persisting use of obsolete, inadequate and sometimes long since replaced test procedures, for example, icterus index, Takata-Ara test, fasting blood sugar in deference to a two hour postprandial blood sugar level, peripheral blood hematocrit level in preparation for transfusion of surgical patients when a body blood hematocrit determination is readily available, red blood cell counts without the valuable red cell evaluation of a differential smear and many others It is understood and appreciated that some of these test procedures are requested out of habit; others are avoided because of excessive cost to the patient. Inadequate habits in medicine, however, must be corrected, and cost to the patient can be minimized by elimination of other extraneous tests with proper selectivity of more informative and serviceable test procedures.

This comment brings another point to mind. A hospital laboratory can render better efficiency

if not harassed by the many unselective test procedures requested in a daily routine. The clinicians must bear in mind that the technologists, serving them and their patients, are not in a position to determine the necessity or validity of a particular test procedure requested for the particular patient. Some clinicians are even indignant at the suggestion of a particular test or diagnosis proposed by an "impertinent" but alert technologist. It is solely the clinician who can and must make these decisions, for example, blood culture necessitated at a given moment, in the face of a sudden rise in body temperature of a given patient with an already preformed differential diagnosis.

Just as an initial blood sugar determination during intravenous administration of glucose in water is unwarranted, with rare exception, so a battery of initial test procedures without adequate clinical evaluation is unwarranted and may lead to erroneous conclusions. Routine cytology (Papanicolaou smears) has successfully supplemented cervical biopsy in early diagnosis of malignant disease; however, screening with all tests available is a routine procedure is an unwarranted abuse of our scientific knowledge, and a poor substitute for the gradually fading out "art of medicine." The art of medicine must be revitalized.

If laboratory procedures were all that was needed to make a diagnosis, then many of our scientific-minded technologists would make excellent diagnosticians. In such case, much of the time spent in medical training and experience of practice could be considered lost efforts in medical training. Fortunately, such is not the case; for the astute diagnostician selects but few test procedures to confirm and isolate his prior-formed diagnosis, based on completeness of history and physical examination. This is the art on which the science of medicine is founded; this is the manner in which science can best serve medicine.

Bernard J. Rumsch, M.D.
Ocala

The Present Status of Anesthesiology

In the darkness with a great bundle of grief
the people march.
In the night, and overhead a shovel of stars for
keeps, the people march:
"Where to? what next?"
The People, Yes—Carl Sandburg

The specialty of anesthesiology has grown steadily since its beginning in the 1930s, until today there are some 7,000 members in the American Society of Anesthesiology. About 3 per cent of the physicians in this country are now practicing this specialty. With this growth the physician anesthetist has become generally accepted, but because of expanding uses and the appearance of problems this new specialty stands today as if on a plateau. Behind it is a struggle to survive and become securely established. This struggle has been won. Ahead is a difficult and a new challenge to the specialty. The challenge is not to its legitimacy but to its responsibility under the social convenant of medicine to give to the best of its ability the care it has been recognized as uniquely competent and qualified to provide.

Just as in other branches of medicine, we are faced with a shortage of anesthesiologists in the future. In a recent survey conducted in Philadelphia among medical students and interns, there appeared a tendency to view anesthesiology as a boring, narrow, unchallenging and technical field. They had serious doubts as to whether it measures up to their standards for a physician's work. This viewpoint is particularly painful to those who have spent much time and effort in promoting this field. The struggle to bring about new techniques in meeting the challenge of modern surgery is something to be held in high esteem and serves as an impetus for future progress. The anesthesia courses given to medical students should be intensified and made practical. All physicians who go into the surgical specialties should also have a basic knowledge of anesthesia and should actually at some time administer the anesthetic to orient them in the many difficult situations that may arise.

Historically, the relationship between the surgeon and the anesthetist has been strained. It seems that the anesthetist must take the blame when anything goes wrong with a case. It will take several more years for this situation to right itself. When true teamwork exists, and both parties work for the welfare of the patient, the barriers will be open for greater harmony.

Obstetricians were also interviewed in the Philadelphia survey. Here again differences were aired. It seems that there is a lack of anesthesia coverage for deliveries in some localities. There are special problems here, but some of the obstacles can be overcome, and I am sure that the future will reveal much more participation by anesthesiologists in this field.

There has been some criticism regarding the "isolation" which many anesthesiologists attempt to maintain with respect to nurse anesthetists. I

think this is unbecoming to us as doctors. It will be many years before anesthesia will be totally a physician's function; so until that time we should be ready to help when a difficult situation arises.

In recent years, the need has arisen for our services outside of the operating and delivery rooms. Respiratory difficulties are common, and the intubation of patients followed by suitable mechanical ventilation has been lifesaving in the emergency, recovery, and intensive care areas.

With the great progress of medicine generally, the specialty of anesthesiology has been of great service to the profession. I am proud to have played a small part in this improvement and have witnessed a remarkable change in the last 20 years when our hospital has advanced from a mediocre to a first class institution.

JOHN D. LINDNER, M.D.
OCALA

A Disgruntled Member

Show me a physician who takes no part in organized medicine and I will show you a disgruntled member of the Florida Medical Association. He vents his envy, compensates for his inadequacies, or salves his conscience by making sarcastic remarks about the medical politicians.

Every new generation has a tendency to disparage the old adages and conceptions. The old one that works is the source of the most happiness comes in for fun-poking particularly in the last few years with our 36 to 40 hour work weeks, et cetera, but doctors know how an idle brain really is the "devil's workshop." When a doctor becomes so highly limited that medicine only interests him in his own practice and not in the county, state, nation and world, he is losing too much of his work potential. A wonderful way for us to combat minor frustrations is to throw ourselves into a job which we know would benefit all of our profession.

There are so many aspects of work in the county and state societies that the particular interest of any doctor could be reached if he would just make a start.

Organizational apathy gets none of us anywhere. A sense of duty should make us work in our medical societies, but we know that is not enough motivation. The plain enjoyment of it should be enough to make everybody try it. It is a wonderful opportunity to swap ideas with our colleagues and to meet some really superior people.

HENRY L. HARRELL, M.D.
OCALA

Association News

FLORIDA MEDICAL ASSOCIATION ORGANIZED 1874

Report of Delegates American Medical Association 1963 Clinical Meeting

The Seventeenth Clinical Meeting of the American Medical Association was held in Portland, Ore., on December 1 to 4, 1963. The final registration was 7,103, including 3,144 physicians. For the first time at a Clinical Meeting, but for the sixth time since its inception, the AMA Layman's Citation for Distinguished Service was awarded. The recipient was Mr. M. Lowell Edwards of Santa Ana, Calif., and Brightwood, Ore., a 65 year old retired engineer, who has designed and built artificial heart valves now in use in more than 2,600 persons with diseased hearts.

Dr. Edward R. Annis, AMA president, reporting on the recent House Ways and Means Committee hearings on the King-Anderson Bill, told the House of Delegates that "the combined testimony of the American Medical Association, the state societies and our allies made a far greater impact on the members of the committee, friend and foe alike, than at any other time in the history of this long and bitter conflict." Also, Dr. Annis reported that under questioning by Committee Chairman Wilbur Mills, actuaries of the Department of Health, Education, and Welfare admitted that the program of tax-paid hospitalization and related benefits for the aged proposed in the King-Anderson Bill would require a tax rate twice as high as they had previously claimed. Dr. Annis was "commended and encouraged in his great work for private enterprise and free American medicine."

Tobacco and health, the rights and privileges of Negro physicians, revision of the AMA Constitution and Bylaws, voluntary health agencies and blood banks were among the major subjects acted upon by the House. Approval was given to a Board of Trustees proposal that the American Medical Association Education and Research Foundation undertake a "comprehensive program of research on tobacco and health." Agreeing that many gaps exist in knowledge about the relationship between smoking and health, the House declared that the study should be "devoted primarily to determining which significant human ailments may be caused or aggravated by smoking, how they may be caused, the particular element or elements in smoke that may be the causal or aggravating agent, and methods for the elimination of such agent."

Two proposals related to Negro physicians were considered by the House. In adopting a Board report on hospital staff privileges, the House urged medical staffs "to study the question in the light of prevailing conditions with a view to taking such steps as they may elect to the end that all men and women professionally and ethically qualified shall be eligible for admission to hospital staff privileges on an equal basis, regardless of race." In this action and in its rejection of a proposed resolution—which would have denied the rights and privileges of AMA membership to members of any state or county society which refuses membership to any qualified physician because of race, religion or place of national origin—the House reaffirmed 1950 and 1952 policy actions on this subject.

Comprehensive revisions and rearrangements of the Association's Constitution and Bylaws included changing Annual and Clinical "Sessions" to Annual and Clinical "Conventions," and "constituent" to "state." Two types

of membership, "Active" and "Special," were created. Active Members are Regular or Service Members. Special Members are Associate, Affiliate and Honorary Members. Affiliate Membership will be available to American physicians engaged in medical missionary and similar educational and philanthropic labors located in possessions of the United States.

In approving a Board report on professional relationships with voluntary health agencies, the House continued its policy of neither approving nor disapproving these organizations and maintained its position of offering guidance on medical aspects of their programs. It directed attention to two obligations: a mutual exchange of information and opinion enabling the medical profession and the agency to understand each other's policy and practice, and on the part of a national voluntary health agency, obtaining the advice of the medical profession when embarking on a national medical program.

The House adopted a policy statement pointing out that in recent years there has been a dramatic growth in blood banking facilities in the United States and declaring that "it is highly essential that the organization of new blood banking programs and the modification of existing ones should have, in the interest of public health and safety, the approval of the county or district medical society and, therefore, should be coordinated with existing approved blood banking facilities." Also approved was a floor amendment stating that since a blood bank can well be considered a medical facility, the top authority in a blood bank should be a physician.

Among miscellaneous actions, the House changed the name of the Council on Scientific Assembly to the Council on Postgraduate Programs, extended AMA Affiliate Membership to scientists in sciences allied to medicine, and expressed gratification that the work of the Committee on Medicine and Religion has received widespread acceptance and support from state and county medical societies, religious groups and other related organizations. It also requested the AMA to seek improvements in the format of its American Medical Directory to make it easier to use and approved recommendations for criteria on medical examinations for driver limitation under certain specified conditions.

The House urged that the term "the aging" be used instead of "the aged" in all statements by the medical profession regarding older persons and approved the "Guides for Medical Society Committees on Aging," recommending their wide distribution and use. It agreed that a short form medical record may be used in cases of a minor nature and, in general, should apply to hospital stays of 48 hours or less. In addition, the House earnestly recommended that the state medical societies explore the advantages of implementing Kerr-Mills programs in a manner which will permit the care of beneficiaries under voluntary health insurance programs, resolved that the AMA attempt to have removed from the Kefauver-Harris Amendment those provisions which authorize the U. S. Food and Drug Administration to determine the effectiveness of drugs, and reaffirmed the Association's policy of opposing the inclusion of self-employed physicians under Social Security.

Respectfully submitted,
Jere W. Annis, M.D.
Burns A. Dobbins Jr., M.D.
Francis T. Holland, M.D.
Meredith Mallory, M.D.
Reuben B. Chrisman Jr., M.D., Chairman

Deaths

Blount, Robert Eames, Leesburg; born in Evansville, Ind., on Nov. 26, 1908; Indiana University School of Medicine, Indianapolis, Ind., 1932; interned at Indiana University Hospitals, Indianapolis, and continued postgraduate study at Massachusetts General and Boston Lying-in hospitals; engaged in the private practice of obstetrics and gynecology in Fort Lauderdale for 25 years and then in Leesburg for the last seven years; during World War II, served with the Army Medical Corps in the China-Burma-India Theatre as a flight surgeon with the rank of first lieutenant; was president of the Broward County chapter of the American Cancer Society for three years; held membership in the American Medical Association, Southern Medical Association and Southeastern Surgical Congress and was a founder-member of the Florida Obstetric and Gynecologic Society and a fellow of the International College of Surgeons; died following a heart attack on Oct. 20, 1963, aged 54.

Citron, Adolph Edward, North Miami Beach; born in New York City in 1904; Boston University School of Medicine, 1930; served in the Medical Corps of the United States Army from 1934 to 1936; had training in his specialty of allergy under Dr. Aaron Brown and later in the Allergy Clinic of Bellevue Hospital, New York City, engaged in the private practice of allergy in Baldwin, N. Y., until 1960 when he came to Florida and continued to practice his specialty in North Miami Beach; held membership in the American Medical Association, the American Academy of Allergy, the American College of Allergists and the Florida Allergy Society; died Aug. 12, 1963, aged 59.

Fitzgerald, Willard Lee, Miami; born in Okolona, Miss., on Dec. 30, 1898; Tulane University School of Medicine, New Orleans, 1923; served an internship in Birmingham, Ala., where he engaged in the private practice of urology until 1931, thereafter continuing his practice in Miami; was a veteran of World War I; was president of the Dade County Medical Association in 1961; was a diplomate of the American Board of Urology, held membership in the American Medical

Association and the American Urological Society and was a fellow of the American College of Surgeons; was a member of the Board of Governors of the John T. MacDonald Foundation and a founder of Doctors' Hospital, Coral Gables; served as Clinical Professor of Urology at the University of Miami School of Medicine; died Oct. 30, 1963, aged 64.

Laffitte, Lincoln Sydnor, Jacksonville; born in Lloyd in 1892; University of Pennsylvania School of Medicine, Philadelphia, 1926; interned at Watts Hospital, Durham, N. C., and served residencies at Bellevue Hospital, New York City, and Grasslands Hospital Tuberculosis Service, Valhalla, N. Y.; as a Rhodes Scholar, earlier received his bachelor's degree in physiology at Exeter College, Oxford, England; while at Exeter during World War I served as an ambulance driver with the Red Cross in France and when the United States entered the war, became a first lieutenant with the 318th Regiment Field Artillery; since 1934 had engaged in the private practice of internal medicine in Jacksonville; was a past president of the Duval County Medical Society; held membership in the American Medical Association and the American Society of Internal Medicine, and was a fellow of the American College of Physicians; died Nov. 9, 1963, after a lengthy illness, aged 71.

Patterson, James Clyatt, Sarasota; born in Troy, Ala., on Feb. 24, 1880; Tulane University School of Medicine, New Orleans, 1910; served an internship at Charity Hospital, New Orleans; engaged in the general practice of medicine and surgery in Malone from 1910 to 1920, in Bartow from 1920 to 1925, and from 1926 to 1963 in Sarasota; served on the State Board of Medical Examiners from 1917 to 1921; was a former president of the county medical societies in Jackson, Polk and Sarasota counties; in 1960 was cited by the Sarasota County Medical Society for 50 years of service in his profession; held membership in the American Medical Association; died Dec. 3, 1963, aged 83.

Robinson, Leigh Fowler, Fort Lauderdale; born in Morgan County, Indiana, on June 20, 1887; Jefferson Medical College, Philadelphia, 1912; served internships at Deaconess Hospital, Indianapolis, Ind., and Gouveneur Hospital, New York City, and after practicing for two years in Indianapolis, served a residency at State Hospital, Raleigh, N. C., in 1916-1917; spent the next three years in the Medical Corps of the Navy with the rank of lieutenant and was assigned to special expeditionary duty with the Marines in Santo Domingo; was director and surgeon of Hospital for Military Government of the Dominican Republic from 1920 to 1925, and since 1925 had practiced general surgery in Fort Lauderdale; was a charter member and a past president of the Broward County Medical Association and had served as chairman of its Executive Committee, Public Health Committee, Legislative Committee, Board of Censors, Board of Trustees and Hospital Committee; in 1939 was President of the Florida Medical Association, served two or more terms as chairman of the Association's Executive Committee, now the Board of Governors, and as chairman of the Scientific Committee, Public Relations Committee, Medical Service Committee and Subcommittee of the Board of Governors for Blue Shield; from 1946 to 1954 served as the first president of Blue Shield of Florida and thereafter for years as honorary chairman of its Board of Directors, and from 1952 to 1954 was a member of Blue Shield Commission representing Blue Shield Plans in Southeastern United States; was a former chairman of the Florida Judiciary Committee of the American College of Surgeons and a member of that organization's Florida Credentials Committee from 1928 to 1958; was appointed by Governor Spessard Holland in 1943 as chairman of Health and Housing of the Florida Defense Council; held membership in the American Medical Association, Southern Medical Association, American College of Surgeons, Southeastern Surgical Congress, Seaboard Surgical Association and American Proctological Society; died Oct. 26, 1963, aged 76.

West, Joseph Ready, Palm Beach; born in Nashville, Tenn., in 1920; Vanderbilt University School of Medicine, Nashville, 1944; interned at Knickerbocker Hospital, New York City, and served residencies at St. Mary's Hospital in West Palm Beach, and Bellevue Hospital, New York City; engaged thereafter in the private practice of internal medicine in Palm Beach; held membership in the American Medical Association and American Geriatric Association; served as vice-chairman of the Medical and Nursing Committee of the Palm Beach County Chapter of the American Red Cross; died in Nashville following open heart surgery on Nov. 25, 1963, aged 43.

Clinical Comment



Geriatrics—The Physician and the Older Patient

The recent postgraduate symposium on Geriatrics—the Physician and the Older Patient given by the Mound Park Hospital Foundation, with the joint sponsorship of the Department of Medical Education of the Mound Park Hospital, the Medical and Research Divisions of Bay Pines Veterans Administration Center, and the American Academy of General Practice, was a positive approach to the better management of the geriatric patient.

Among those participating in this teaching course were Dr. Maurice E. Linden, Director of the Division of Mental Health, City of Philadelphia; Dr. Bacon F. Chow, Associate Professor of Biochemistry at Johns Hopkins University; Dr. Charles H. Barrows Jr., Chief of the Nutritional Biochemistry Section of the Gerontology Branch, National Institutes of Health, National Heart Institute, Baltimore; Dr. William C. Spring Jr., Secretary of the Council on Drugs of the American Medical Association; Dr. Edward Henderson, Editor-in-Chief of the Journal of the American Geriatrics Society; Dr. H. Max Houtchens, former Chief of the Psychology Division of the Veterans Administration Central Office, Washington, D. C.; and Dr. Charles K. Donegan, President of the American Society of Internal Medicine.

The guest faculty, augmented by a faculty of staff physicians, gave an intensive and impressive course, and the subject matter covered the various fields of medicine, surgery, orthopedics and dietetics, as well as certain socioeconomic factors as related to the older patient.

Dr. Spring said that in consideration of the medical problems of the aged, all too often it is assumed that if miracles cannot be performed, nothing less is worth while. When drugs are properly used, they play an important role in the management of geriatric problems. He said that proper drug usage has what may superficially appear to have a negative side, especially in geriatrics, and that in this field precautions essential to proper drug usage are particularly in need of being stressed.

In general, he said, nature alone does a very efficient job in handling much of what ails us from time to time. This is less true, however, in the geriatric individual, who, therefore, should have even more careful individualization of therapy, when nature needs assistance, than does the patient in his prime. As far as possible, any therapeutic regimen should also fit into rather than disrupt the patient's pattern of living.

Dr. William K. Barton, staff surgeon, speaking on the risks and results of surgery in the elderly, said that there are many situations where the patient is an extremely poor risk, but the disease is not curable without surgery, such as ruptured abdominal aneurysm, intestinal obstruction, and perforated viscera. We should consider the life expectancy of the elderly at the various ages since in evaluating the surgical risk, we should at least think that the patient will live long enough to enjoy the benefits of the surgery. In lessening the surgical risk, the single most important factor is that of maintaining as near normal physiology as possible, and during surgery when it is necessary to alter that physiology, the period of time that it is to be altered should be kept as short as possible. Various other factors must be considered in the evaluation of surgical risk, such as obesity, nutritional status, loss of protein blood elements, salts, chronic illness, debilitated states, underlying heart disease, liver disease, and other conditions in which the risk may be greatly increased.

Dr. Irwin S. Leinbach, staff orthopedic surgeon, spoke on special treatment of the aged arthritic patient. He emphasized that no surgical measures should be taken unless there is reasonable assurance that they will decrease pain and improve function. He covered the subjects of rheumatoid arthritis, osteoarthritis and the surgical treatment of arthritis of the hip.

There is little doubt that a thorough understanding of geriatric medicine must play an im-

Under this heading, The Journal presents information gathered by Florida physicians attending the various medical meetings. The thoughts expressed are those reported by the author and are not intended as scientific references.

portant role in everyday practice. The geriatric patient is bound to occupy an ever increasing place in the patient load, and the need for a rational and intelligent approach necessarily becomes more pronounced.

M. A. Barton, M.D.
St. Petersburg

The Florida Orthopedic Society

The Florida Orthopedic Society held its spring meeting on Saturday, May 18, at the Diplomat Hotel, Hollywood. The moderator, Wallace E. Miller, M.D., of the University of Miami School of Medicine and Jackson Memorial Hospital, Miami, introduced the guest speaker, William H. Bickel, M.D., President-Elect of the Academy of Orthopaedic Surgeons and head of the orthopaedic section at Mayo Clinic, Rochester, Minn. Dr. Bickel spoke on "Problems and Complications in Hip Surgery." In summary, he said:

Frequently, if the problem hip is analyzed carefully, complications and troubles can be avoided. The patient himself must be selected carefully, taking into consideration his physiologic age and his temperament as well as his physical status.

The operation selected for a specific hip should serve the purpose it is designed for and fit the situation at hand. Consideration must be given to the occupation and desires of the patient. There are "standing hips and walking hips and sitting hips."

Many times the problem is complicated by previous significant disease, such as tuberculosis or pyogenic infections, and any surgical procedure is doomed to failure and the patient to miserable disaster if this problem is not under control.

Previous operations which have failed for a multitude of known and some unknown reasons represent the bulk of the hip complications which present themselves for salvage. The problem then resolves itself into what does one have left to work with and what can be reconstructed. The problem varies in every case and best laid plans for reconstruction sometimes have to be altered at the operating table. It is important that the surgeon be familiar with the multitude of procedures possible and have the equipment at hand to do the best possible job.

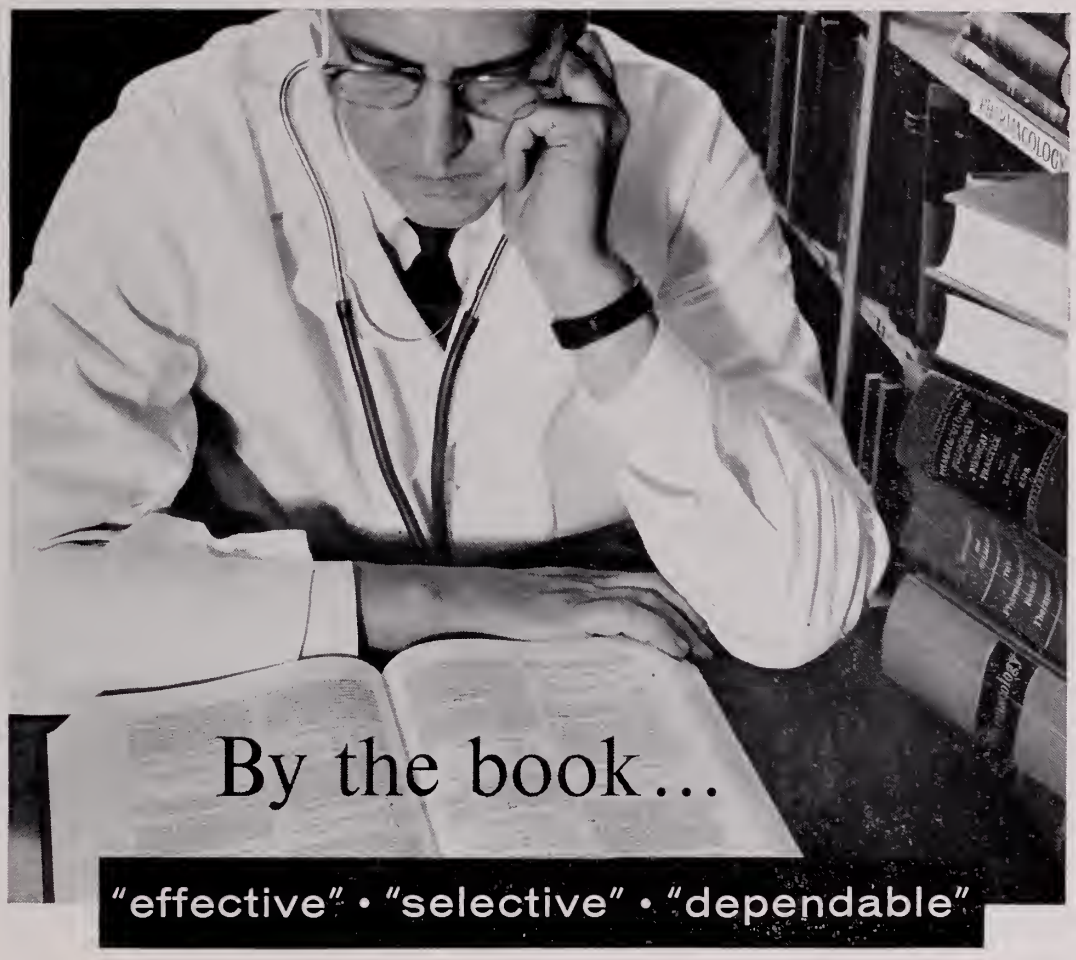
Finally, it is believed that the postoperative care and rehabilitation are as important as a properly executed operative procedure. If stability is desired, proper immobilization must be secured for an adequate length of time. If mobility is desired, a good program of muscle and bone restitution should be outlined and followed. Full ambulation and weight bearing can be attained only when the muscles are strong and the bone is sufficiently hard to permit what is demanded of them.

One can suggest specific operative procedures, but every case is different and the choice should depend on the situation presented and the experience of the surgeon with the varied procedures available.

The remainder of the program was produced by the members of the Florida Orthopedic Society. The first presentation was by Newton C. McCollough, M.D., of Orlando, who spoke on an operative procedure similar to the original Girdlestone procedure, but titled by the speaker as "Let 'er Fly." Dr. McCollough reported 30 cases of pseudoarthrosis of the hip. Eight patients had nonunion of a subcapital fracture with absorption of the neck of the femur but with retention of the head of the femur. The other patients showed the result of removal of the head and neck of the femur in painful osteoarthritis. Twenty-four of these patients achieved a good result, four had a fair result, and one had a poor result. The majority could walk well with a cane and had no pain. Those with fair results had some pain. The patient with the poor result was never able to get out of bed or ambulate without pain.

Dr. McCollough stressed redevelopment of the hip musculature by using resistive exercises as the most important factor in producing a painless or relatively painless hip and good gait. The resulting gait could be accepted as a good gait if one allows for a "toe-out" which was the result of the external rotation. A good range of motion was present in abduction, flexion and adduction, but internal rotation was often poor or absent. Not a single one in his series had less than 90 degrees of flexion. The upward excursion of the trochanter when weight was placed entirely upon the affected foot averaged from ⅜ inches to ½ inch. The amount of lift utilized was sufficient to make the patient comfortable and varied from none to 1 or 1½ inches, the average being in the neighborhood of 1 inch.

Another presentation was given by James R. Brandon, M.D., of West Palm Beach, on "Some Experiences with Bilateral-lateral Lumbar Spine Fusion." Dr. Brandon reviewed 15 cases and cited the technical difficulties of increased operating time and increased blood loss, as compared with classical spine fusion methods. Measures to cope



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with these problems were suggested. Preliminary evaluation of the cases suggested the following impressions:

1. The convalescent period seemed less painful than with the usual spine fusion and the patient was active sooner.

2. The incidence of nonfusion appeared to be less than by other techniques.

3. The laminae were not covered by a massive graft, suggesting an easier procedure should a subsequent disc exploration be required. Dr. Brandon thought that a larger series and longer follow-up would be required for valid conclusions.

A third presentation was given by the chairman of the Department of Orthopedics at the University of Florida College of Medicine, Gainesville, William F. Enneking, M.D., who spoke on "Salvage Procedure of the Hand." A seven year old boy was presented who had sustained a loss of the thumb, index and long finger as a result of a dynamite blast. The transfer of the index toe of the contralateral foot was utilized to reconstruct the hand and provide the patient with a thumb with sensation, motion and a suitable cosmetic appearance. Dr. Enneking showed that these objectives had been realized in a four year follow-up of the case.

The fourth presentation was a discussion by Philip C. Lichtblau, M.D., West Palm Beach, and Dr. Miller on "The Smashed Heel." Both physicians had a patient who had similar problems as the result of a fall from a height which had left the patient with bilateral painful heels as the final residual following a long series of operative procedures to correct this distressing situation. The presentation stressed there was not the usual problem relative to the fracture of the os calcis in these two cases but rather one of a crushing of the heel pad and the protective soft tissues in association with the crushing of the bone which left the patient with the residual of a smashed heel. No solution was pointed out for the future care of this type of injury, but there was an indication that the triple arthrodesis or operative fusions that had been suggested in the past are of no avail in this type of case. It was suggested that restoration of the height of the os-calcis would make shoe wear easier and partial denervation aids in the relief of pain.

Wallace E. Miller, M.D.
Associate Professor of Orthopaedics
University of Miami School of Medicine
Miami

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News

The third sectional meeting of the American College of Surgeons is being held in New Orleans at the Roosevelt Hotel on May 16-19.

A Conference on Bone Tumors is being presented by the Duval Orthopedic Society in conjunction with the North Florida Radiological and Pathological Society on February 22 at the Duval Medical Center in Jacksonville beginning at 9:00 a.m. Speakers are Drs. H. Jaffe, pathology, and H. Jacobson, radiology, of New York City, and Dr. William F. Enneking, orthopedics, of Gainesville.

Glaucoma screening is being conducted at the Florida State Fair in Tampa, February 4-15, sponsored by the Florida Society of Ophthalmology and Otolaryngology and the Florida Society for the Prevention of Blindness in cooperation with the Florida State Board of Health. Dr. Hugh E. Parsons of Tampa is the medical chairman and serving on the committee with him are Drs. Bernard T. Bell and Orville N. Nelson of St. Petersburg. All tonometry will be done by ophthalmologists and referrals made to the family physician or an ophthalmologist in the local community.

The Annual Watson Clinic Seminar has been scheduled for March 7 at Lakeland.

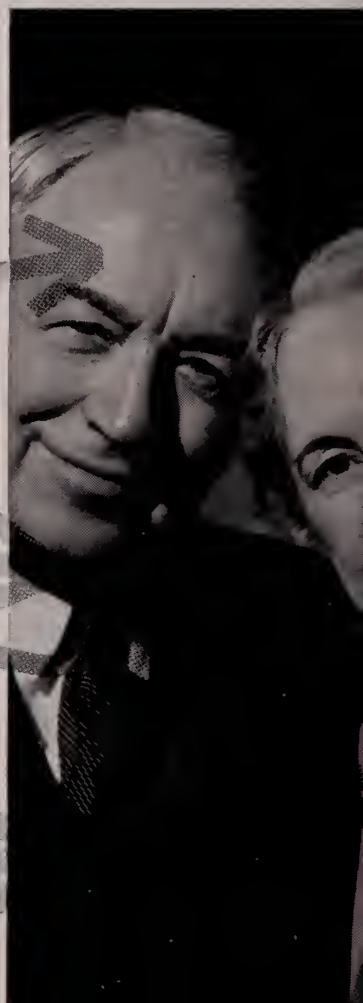
The Sixth Annual Medical Forum sponsored by the Lee-Hendry County Medical Society and the Lee County Chamber of Commerce is being held March 4-5 in the Exhibition Hall at Fort Myers.

A Cancer Seminar is being presented March 6-7 by the Pinellas County Unit of the American Cancer Society at the Fort Harrison Hotel in Clearwater. The program begins at 9:00 a.m. each day.

The Fourth Annual Meeting of the Florida Cleft Palate Association will be held in Jacksonville February 7-8 at the George Washington Hotel.

The 1964 Atlanta Graduate Medical Assembly has been scheduled for February 17-19 at the Biltmore Hotel in Atlanta. Specialties being featured on the program include medicine, surgery, cardiology, obstetrics, gynecology and pediatrics.

increases blood flow to the brain in the "senility syndrome" associated with cerebrovascular insufficiency



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references: 1. Madow, L.: Penn. M. J. 62:861, June 1959. 2. Stieglitz, E. J.: Geriatric Medicine, ed. 2, Philadelphia, Saunders, 1949 p. 274. 3. Winsor, T., et al.: Amer. J. Med. Sciences 239:594, May 1960. 4. Eisenberg, S.: ibid, July 1960.

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[1] Simon, F. & Bernstein A.: "The Treatment of Obesity in Patients with Cardiovascular Disease," Angiology, *12*:32-37, Jan. 1961.
[2] Plotz, M.: Modern Management of Obesity, J.A.M.A. *170*:1513-1515 (July 25) 1959.
[3] Bernstein, A. & Simon, F.: "Treatment of Obese Diabetics and Arteriosclerotics," Clin. Med. 907-920, May 1961.

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Meetings

February

Central Florida Medical Meeting, Tenth Annual, Orange County Medical Society, February 15, Cherry Plaza Hotel, Orlando.

March

Sixth Annual Medical Forum, Lee-Hendry County Medical Society and Lee County Chamber of Commerce, March 4-5, Exhibition Hall, Fort Myers.

Cancer Seminar, Pinellas County Unit of American Cancer Society, March 6-7, Fort Harrison Hotel, Clearwater.

Annual Seminar, Watson Clinic, March 7, Lakeland

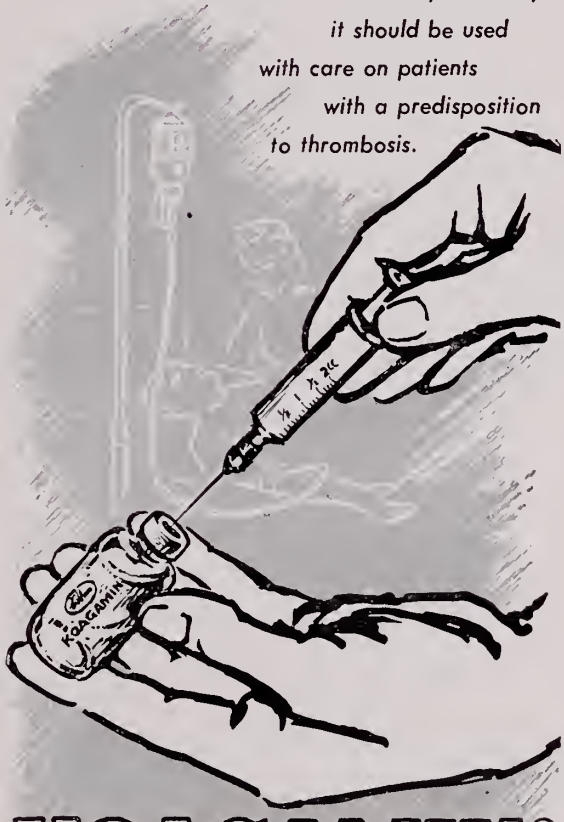
"Evolving Concepts in Pulmonary Diseases," Department of Radiology, University of Miami School of Medicine and Jackson Memorial Hospital, March 18-21, Hotel Fontainebleau, Miami Beach.

Southeastern Surgical Congress, March 21-28, S. S. Hanseatic sailing from Port Everglades, Fort Lauderdale.

"Principles in the Rehabilitation of the Physically Handicapped," Crippled Children's Society of Dade County, March 2-6, Rehabilitation Center, Miami.

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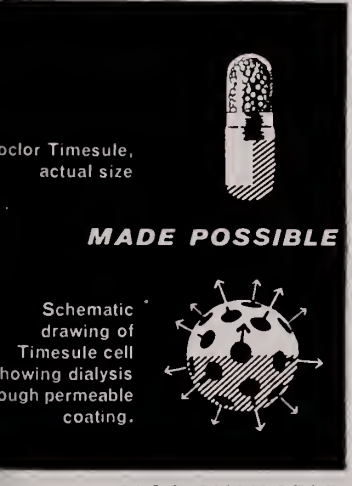
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References: 1. Levine, R.: Rationale for the Use of Adrenal Steroids, Paper presented at Annual Convention, Medical Society of the State of New York, New York, May 13-17, 1963. 2. Hollander, J. L.: Clinical Use of Dexamethasone. *JAMA 172*:306 (Jan. 23) 1960. 3. Boland, E. W.: Chemically Modified Adrenocortical Steroids. *JAMA 174*:835 (Oct. 15) 1960. 4. McGavack, T. H.: The Newer Synthetic Adrenocortical Steroids in Therapy. *Nebraska Med. J. 44*:377 (Aug.) 1959. 5. Freyberg, R. H.: Berntsen, C. A., Jr., and Hellman, L.: Further Experiences with Δ1, 9 Alpha Fluoro, 16 Alpha Hydroxyhydrocortisone (Triamcinolone) in Treatment of Patients with Rheumatoid Arthritis. *Arthritis Rheum. 1*:215 (June) 1958. 6. Cahn, M. M. and Levy, E. J.: Triamcinolone in the Treatment of Dermatoses. *Amer. Practit. 10*:993 (June) 1959. 7. AMA Council on Drugs: New and Nonofficial Drugs. *JAMA 169*:255 (Jan. 17) 1959. 8. McGavack, T. H.; Kao, K.-Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: Clinical Experiences with Triamcinolone in Elderly Men. *Amer. J. Med. Sci. 236*:720 (Dec.) 1958. 9. Fernandez-Herlihy, L.: III. Use and Abuse of Corticosteroid Therapy—The Structure and Biologic Activity of the Corticosteroid Hormones and ACTH, *Med. Clin. N. Amer.* 44:509 (Mar.) 1960. 10. McGavack, T. H.: Triamcinolone: A Potent Anti-inflammatory Sodium Excreting Adrenosteroid. *Clin. Med. 6*:997 (June) 1959.

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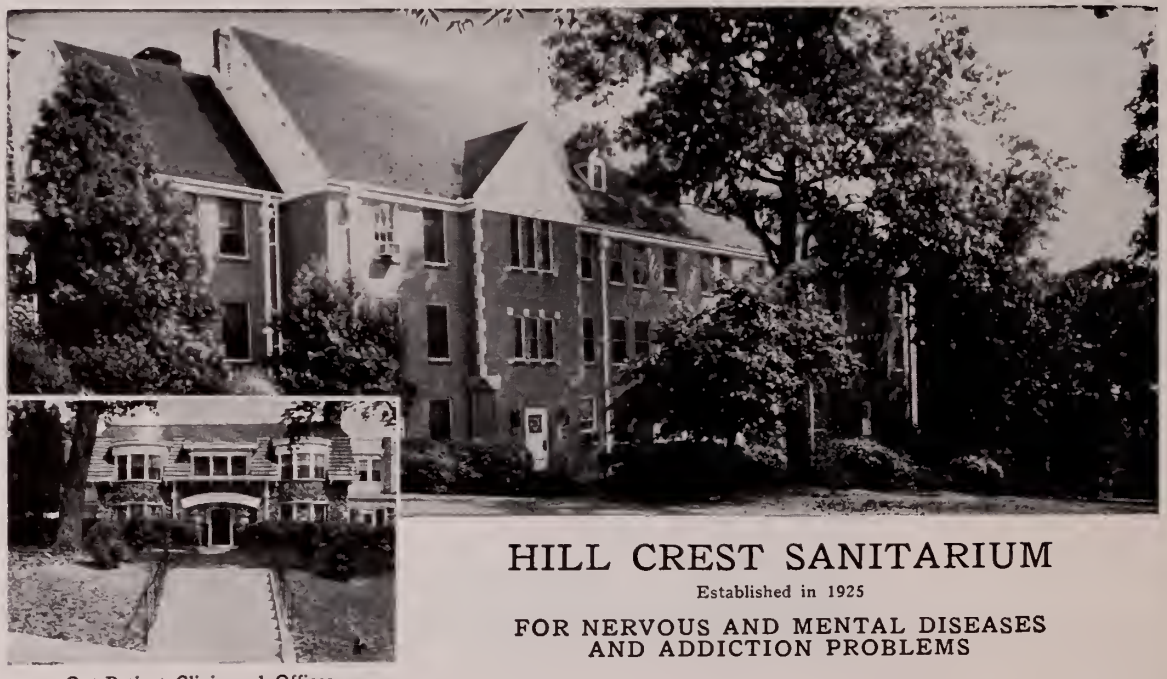
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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).



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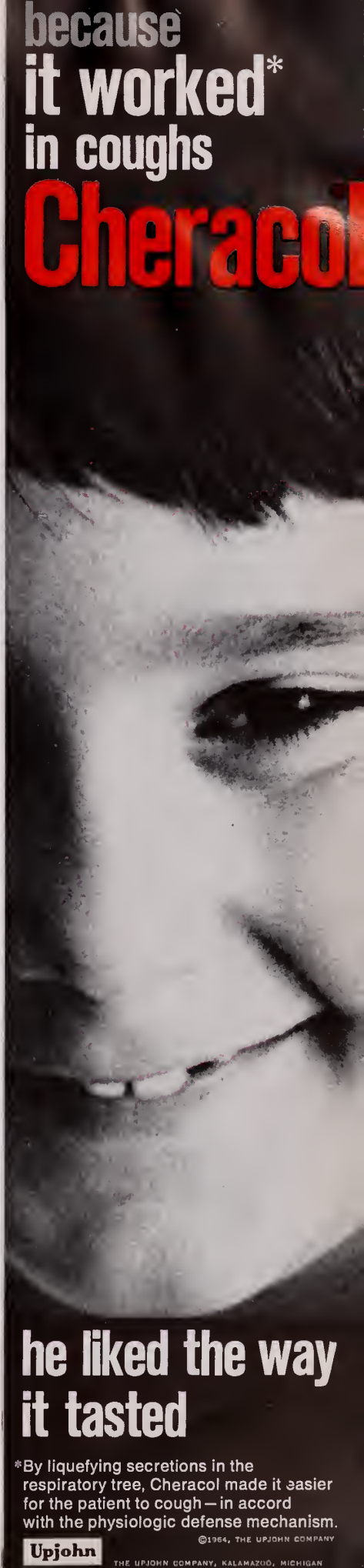
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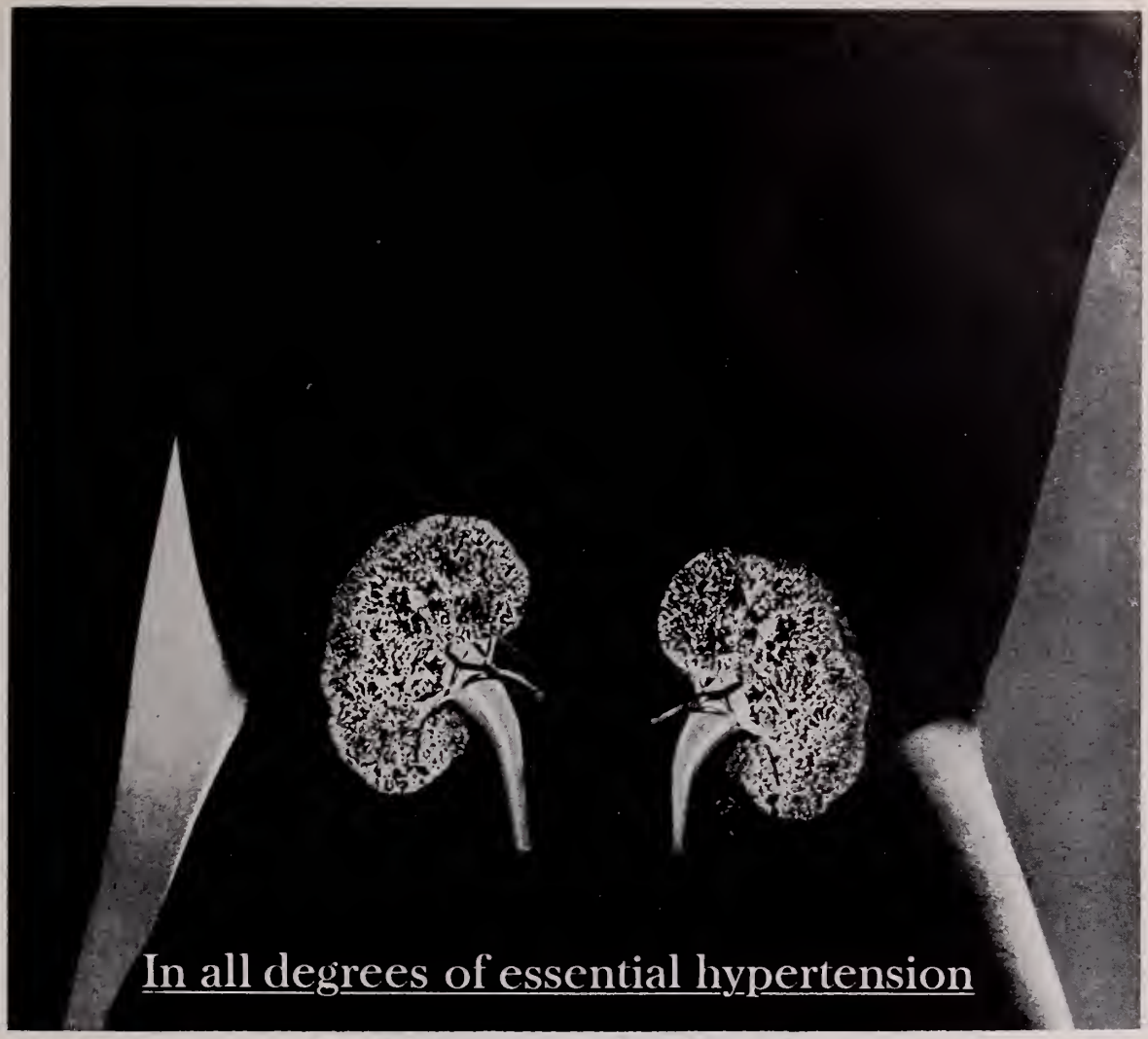
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*Roseman, E.: *Neurology* **11**:912, 1961. 33664

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References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

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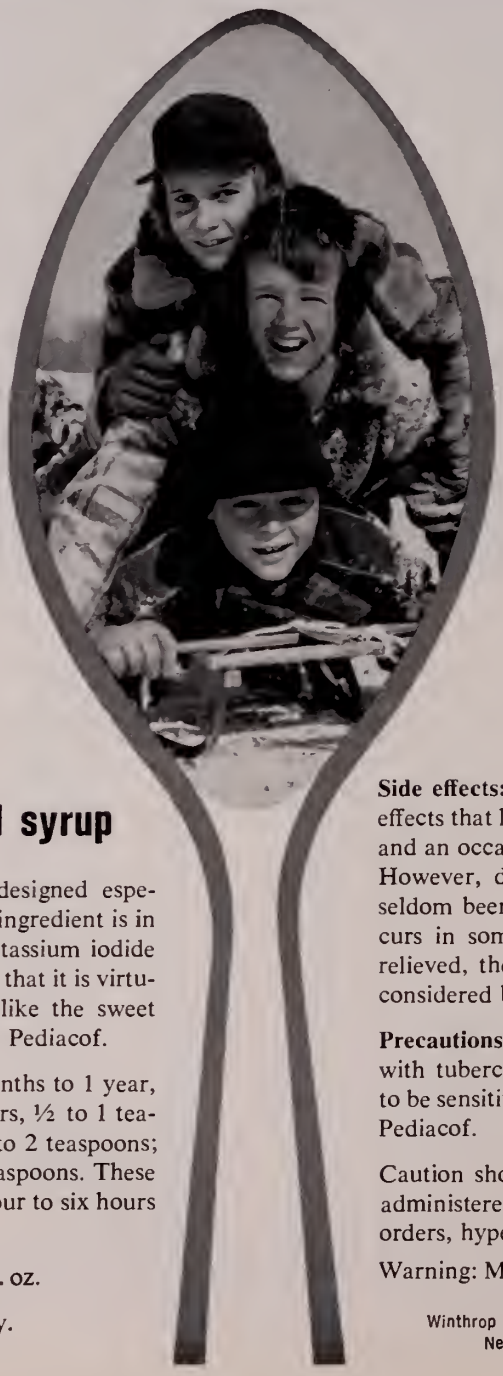
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Volume 51, Number 3, March 1964

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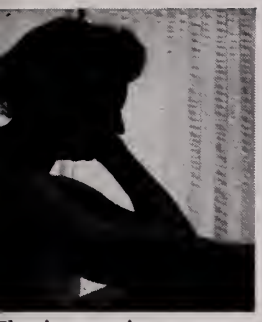
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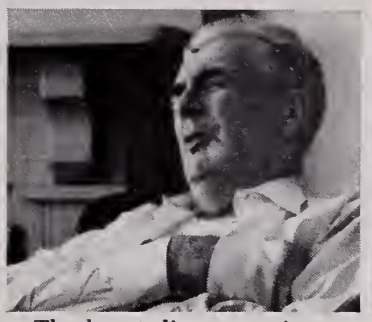
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The insomniac



The tense, nervous patient



The heart-disease patient



The surgical patient



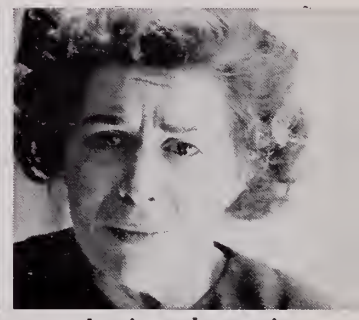
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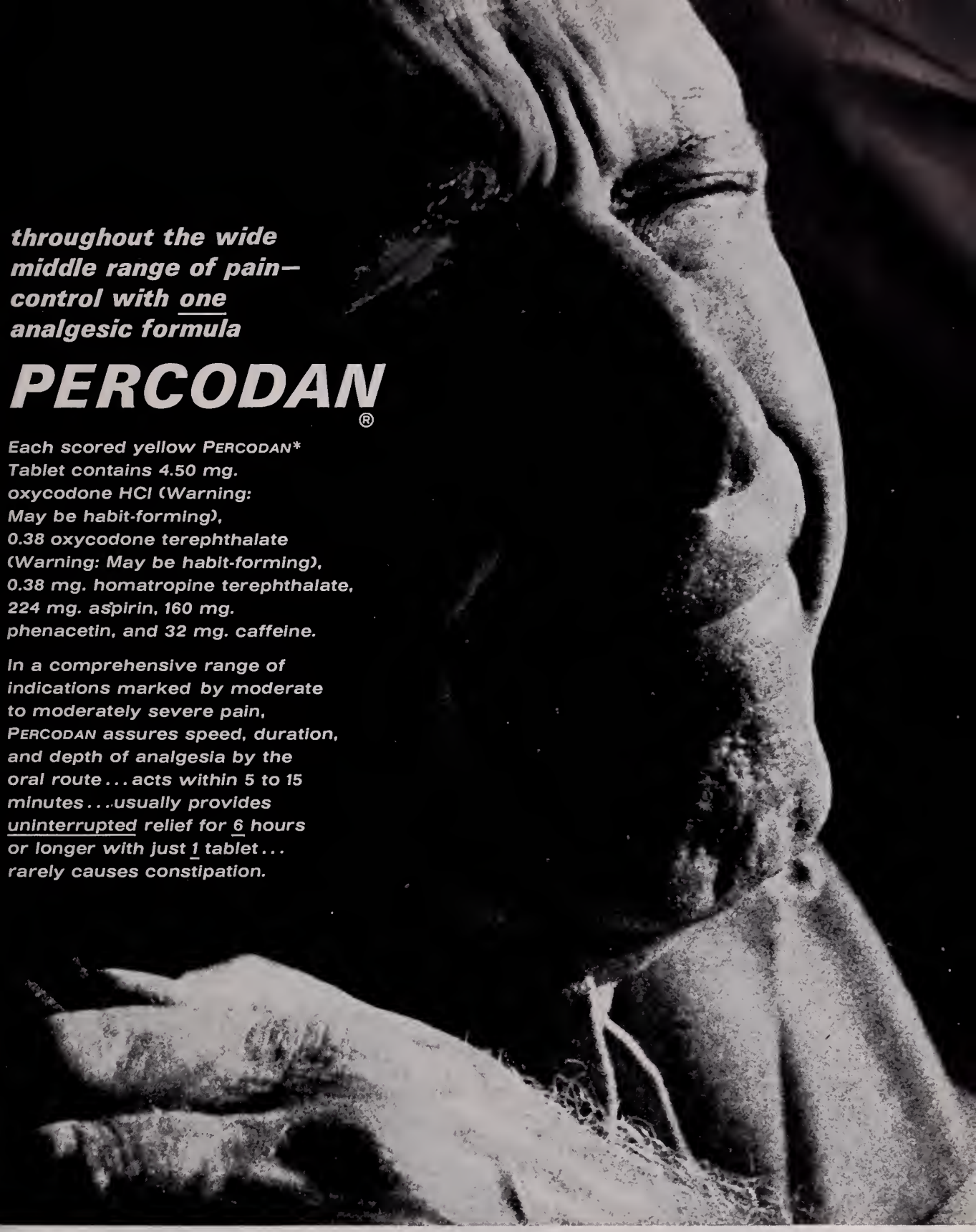
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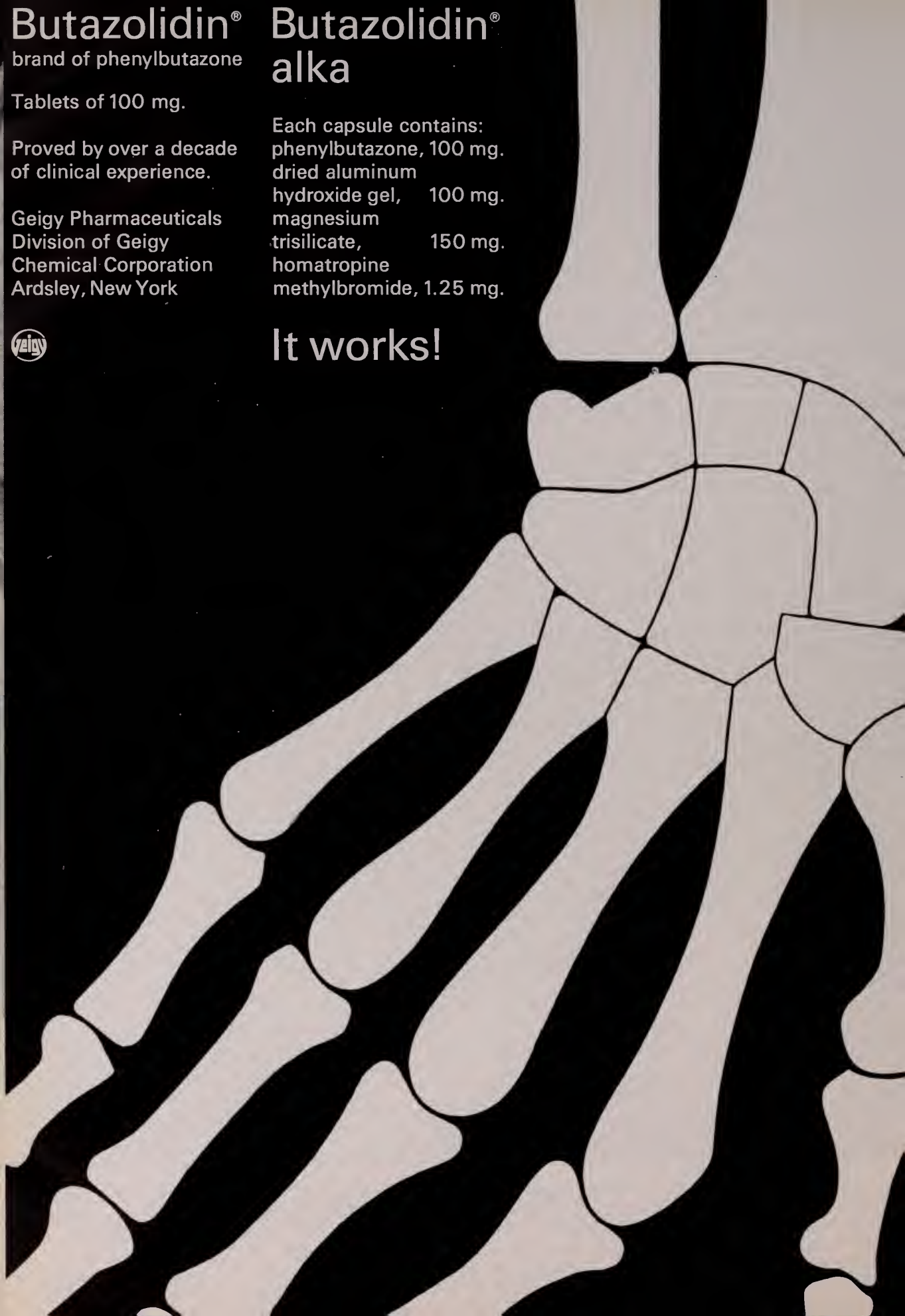
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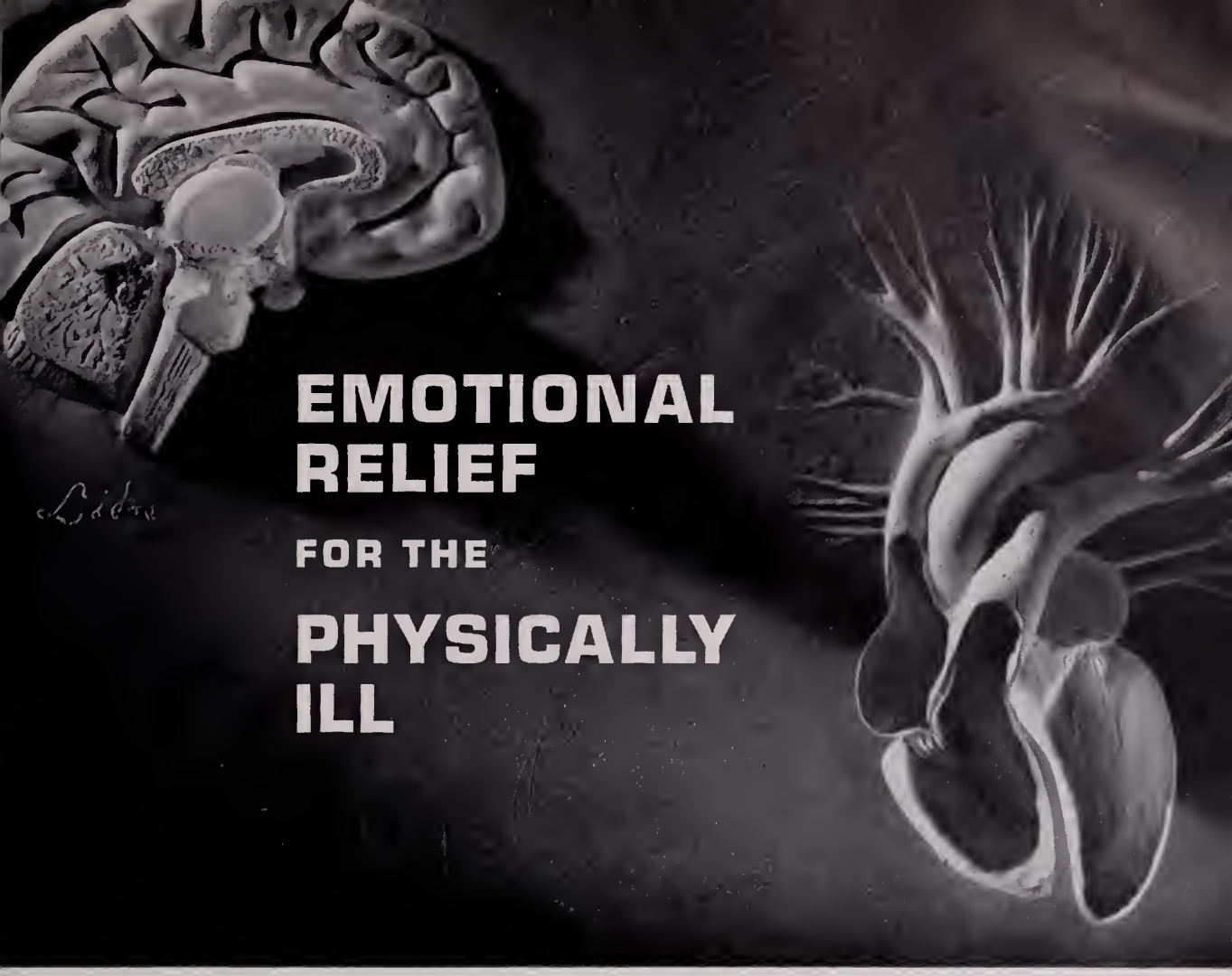
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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).



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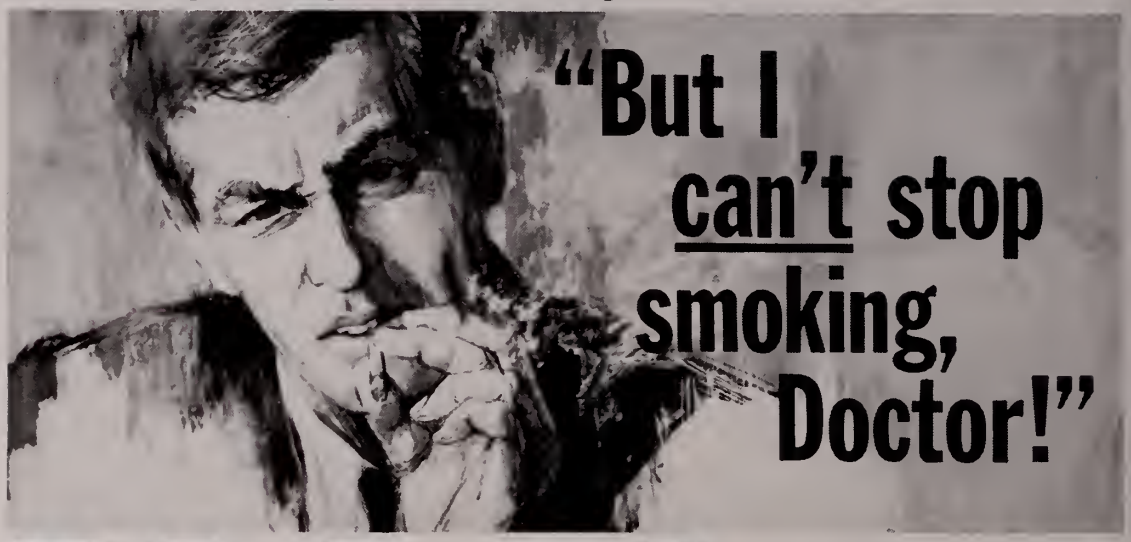
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The Radiological Study of Renal Artery Stenosis

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Considerable interest in renal artery stenosis as a cause of diastolic hypertension has developed in recent years. This has been generated by reports of substantial numbers of patients in whom the hypertension has been relieved by renal artery reconstruction and nephrectomy. This paper will report six patients with renal artery stenosis and hypertension and will outline the radiological contributions to establishing the diagnosis of renal artery disease.

Narrowing of a main or segmental renal artery from any cause is thought to lower the pulse pressure and/or blood flow to the distal kidney. In some manner, this initiates events leading to the production of the pressor substance, angiotensin. Angiotensin may also interact with the adrenal cortex, resulting in excessive secretion of aldosterone.[1] Renal artery reconstruction is aimed at restoring sufficient renal blood flow to stop the events leading to angiotensin formation and to save kidney function.

Clinical Findings

The main etiological groupings of renal artery disease are atherosclerosis and fibromuscular dysplasia. Aneurysms of the renal artery and coarctation are occasionally encountered. Stenosis has been found in all age groups. Fibromuscular dysplasia is most common in young adults, especially women. Some authors have suggested that renal arteriography be performed on all patients in whom hypertension develops below 30 years of age or over 50 years of age, even if the diagnostic tests which usually precede renal arteriography give negative results.

The hypertension of renal artery stenosis is usually severe and unrelenting. Mild or fluctuating pressure levels, however, do not exclude the disease. While failure to respond adequately to antihypertensive medication is common in this entity, responsiveness also has been reported.[2] Negroes are infrequently afflicted with this disease. A bruit may be heard over the upper part of the abdomen. A lack of a familial history of hypertension is typical. The onset of hypertension may be sudden and accompanied by pain in the flank. The hypertension may be of long or short duration. A sudden acceleration of the severity of hypertension may indicate the presence of renal artery stenosis. The appearance of azotemia in the course of chronic renal disease and hypertension may signify the engraftment of renal artery stenosis upon the already compromised kidney. Morris and his associates[3] reported a fascinating group of 12 such patients with good results in 11 patients following surgery.

Diagnostic Procedures

The first problem in the diagnostic work-up is the selection of appropriate patients for renal arteriography. The second problem is selection of patients for surgery from amongst those with demonstrated renal artery stenosis.

Some authors have thought that their approaches really solve both problems simultaneously. Without delving into the merits or disadvantage of these systems, some of the techniques will be mentioned and the procedures that we employ will be discussed.

From the Departments of Radiology of the Baptist Hospital of Miami and of the University of Miami School of Medicine. Clinical Instructor (Dr. Sneider) and Clinical Associate Professors (Dr. Winslow and Dr. Pryor).

We have performed radiorenograms and the place of this procedure is yet to be determined in our investigations. In case 2 in our series, the left radiorenogram tracing was within normal limits, but obvious artery stenosis was present. None of the six patients comprising the series had split-function tests. The Howard test and modifications of this test have their advocates.[2,4] The difficulties of these tests lie in the need for bilateral ureteral catheterization and the confusing results found in the presence of bilateral renal artery disease.

The intravenous pyelogram and a modification of the standard x-ray procedures are the mainstays of our radiographic diagnostic work-up. All six patients had abnormal urographic findings. Briefly, the major abnormal urographic findings are: (1) Different renal sizes with 1.0 cm. difference in greatest length of the two kidneys as a useful minimum difference. (2) Nonvisualization of part or all of an unobstructed renal collecting system. (3) Delayed appearance of the contrast material. Early films should be obtained since the delay may be only transient. (4) Increased density may be present on the abnormal side throughout or late in the study. (5) The abnormal side may show only a spider-like collecting system representing a "low flow" pattern of urinary output. (6) Notching of the upper ureter from collateral circulation is occasionally seen.

Recently, we have modified the pyelographic study along lines described by Amplatz.[5] The dehydrated patient is given 30 cc. of 50 per cent Hypaque intravenously and films of the kidneys are obtained at varying intervals from 30 seconds to 10 minutes. These allow evaluation for any of the findings described in the preceding paragraph. At 10 minutes, a rapid intravenous infusion of 1,000 cc. of 5 per cent glucose in water is started containing 50 cc. of 25 per cent mannitol. Interval radiographs are taken to observe the fading of the contrast material now under hydrated and diuretic conditions. An ischemic kidney will retain the Hypaque longer than the normal kidney and a differential "washout" will be seen. We have also used urea as the diuretic as suggested by Amplatz.[5] Mannitol is possibly a safer agent than urea when infused rapidly. The use of an infusion of glucose in water is also being evaluated.

Sutton, Brunton and Starer[6] and Birchall, Batson and Brennan[4] each reported a case in which the patient was hydrated with 500 cc. of water before urography and the ischemic kidney showed fairly dense excretion of contrast material, while the normal one was barely perceptible. The advantage of the flush intravenous pyelogram is that it provides a study of the kidneys in both the dehydrated and hydrated states in one diagnostic session. The diagnostic value of hydration is based on the characteristic defect of the ischemic kidney, namely, excessive tubular reabsorption of water. This excessive reabsorption accounts for the lower urinary output from ischemic kidneys found by split-function tests. A Howard test is positive when the abnormal kidney excretes 50 per cent less urine and 15 per cent less sodium, relative to the normal kidney. Hypaque is excreted almost exclusively as a glomerular filtrate.[5] The excessive water reabsorption in ischemic kidneys leads to higher concentrations of glomerular filtrates, and, thus, the Hypaque appears denser and is visualized longer on the ischemic side. The importance of slight differential washouts remains to be determined. The effect of bilateral renal artery stenosis on this radiographic split-function test is not yet known.

Stamey and his associates[7] have discussed the use of urea and mannitol as osmotic diuretics. According to these authors, urea will accentuate the differences between ischemic and nonischemic kidneys, while mannitol will decrease the differences. The effects of these two diuretics, however, may not be too dissimilar at urinary flow rates greater than 2 ml./min. The value of either of these diuretics or of the infusion of glucose in water in the washout intravenous pyelogram remains to be determined in regard to the ability consistently to select ischemic kidneys.

The definitive procedure for the diagnosis of the renal artery stenosis is renal arteriography. Whenever feasible, we employ percutaneous femoral artery puncture with retrograde passage of a catheter. With this technique, alterations in the level of the catheter tip are easily accomplished and a free flow injection of contrast material into the aortic lumen can be made. An injection by hand was done in our earlier experience, and recently a Cordis power injector has been used. Translumbar aortography has been used with great success also. This technique, however, requires repuncture if it is necessary to alter the needle position and sometimes the contrast material jets against one wall of the aorta or into one renal artery (fig. 1).

Once renal artery stenosis has been demonstrated, a decision for or against arterial reconstruction or nephrectomy must be made. In the two large American series of cases of renal vascular hypertension reported by Morris and his associates[3] and Poutasse,[8] this decision was apparently based mainly on the arteriographic appearance of the renal arteries.

The possibility that the pressure gradient determined at operation between the aorta and the renal artery distal to the stenosis would give some indication of response to surgery has been raised. The presence of any gradient requires at least a 50 per cent reduction in lumen diameter. Morris and his associates[3] reported that 24 per cent of their patients had gradients less than 25 mm. Hg and that the gradient size had no prognostic correlation with response to revascularization.

Report of Cases

Renal arteriography has been performed in 16 hypertensive patients. In eight of these, the preliminary intravenous pyelogram was considered abnormal. The other eight had renal arteriography on the basis of age or other clinical information and all of these arteriographic studies were normal. The arteriograms in the patients with the abnormal intravenous pyelograms showed renal artery stenosis in six; the disease was bilateral in two of these six. Brief reports of these six cases are presented:

Case 1.—A 61 year old white man had a history of hypertension for one and a half years. Recently, the pressure levels had varied between 180/100 and 210/90 mm. Hg and were unresponsive to medication. He was admitted to Baptist Hospital in November 1961. Intravenous and retrograde pyelography showed a smaller right kidney, which barely visualized, but was not obstructed. Right renal artery stenosis with poststenotic dilatation was shown by arteriography (fig. 2). In November 1961, he underwent a right renal artery endarterectomy with a patch graft. An arteriosclerotic plaque was felt in the left renal artery and endarterectomy was performed; technical difficulties were encountered in the left renal artery surgery. A follow-up intravenous pyelogram in March 1962 showed good visualization on the right side and some decrease in visualization on the left side. The blood pressure dropped to normal levels and was recorded at 130/80 mm. Hg in May 1962. This patient died in September 1962, 10 months following renal artery surgery. He had resumed normal activity during that period. Acute myocardial infarction and generalized arteriosclerosis were found at autopsy.

His sudden death from coronary artery disease points out again the lethality of arteriosclerosis and it is self-evident that successful surgical intervention for this disease in one artery does not prevent the risks of arteriosclerosis in other arteries.

Case 2. —A 52 year old white man had a history of hypertension for 10 years. This patient had an excretory urogram study at another hospital in August 1960. This study showed a smaller right kidney and a low flow pattern. Fourteen months later, he was admitted to Baptist Hospital and no change was apparent in the urogram. His blood pressure was 260/140 mm. Hg. Arteriography showed bilateral renal artery stenosis with prominent poststenotic dilatation on the left side (fig. 3). In February 1962, a bilateral renal artery bypass dacron graft was put in place in the form of an inverted "Y"



Fig. 1. — Translumbar aortogram demonstrating jet of contrast material into the right renal artery. Replacement of the needle would be required to visualize the left renal artery.

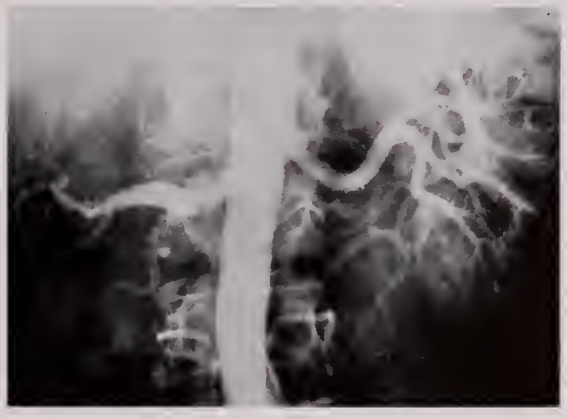


Fig. 2. — Case 1. Retrograde femoral arteriogram with arteriosclerotic plaque narrowing the right renal artery. The left renal artery was considered normal.



Fig. 3. — Case 2. Retrograde arterial study showing bilateral renal artery stenosis. The left kidney was larger than the right.



Fig. 4. — Case 4. Retrograde left brachial needle aortogram showing aortic occlusions and collateral circulation. The left renal artery was severely stenosed.



Fig. 5. — Case 5. Thirty minute film of flush intravenous pyelogram showing differential washout with denser contrast material in smaller collecting system in the left kidney.

with the single limb attached to the anterior surface of the aorta below the origins of the renal arteries and the two other limbs anastomosed with the renal arteries beyond the stenotic areas.

He became normotensive for six months and then there was recurrence of elevated blood pressure. In August and September 1962, he was restudied. The intravenous pyelogram showed function only from the right uppermost calyx; the renal arteriogram demonstrated occlusion of the major right renal artery and of the bypass graft; the left renal artery was as before. A radiorenogram was abnormal on the right, but the left tracing was considered within normal limits. The pressure at this time was 220/140 mm. Hg; medication brought this down to 150/90 mm. Hg by February 1963. Since that time, however, some escape from medication control has appeared and the blood pressure levels have reached 180/110 mm. Hg.

An awareness of subtle changes in the urogram, which might reflect an underlying renal arterial stenosis is a significant part of the radiological work-up. In this case, the changes were originally seen, but were not correlated with the hypertension. It might be useful in some situations to review previous urograms of patients studied for hypertensive disease prior to the newer concepts of urographic abnormalities.

This patient was normotensive for a short period following surgery. The recurrence of hypertension is attributed to the failure of the surgical procedure. A second operation is being considered.



Fig. 6. — Case 5. Retrograde femoral arteriogram with bilateral renal artery stenosis and occluded left iliac artery.

Case 3.—A 57 year old white woman was hospitalized in August 1962, with a long history of hypertension and a blood pressure of 175/105 mm. Hg. The left kidney was 1.4 cm. larger than the right one. The renal arteriogram showed two arteries on the left side with narrowing of the origin of the lower one and some apparent poststenotic dilatation. At surgery, no plaques were felt in this artery and a sharp angulation was noted. Pressure gradients indicated a 13 mm. Hg drop from the aorta into this artery. No reconstructive surgery was performed. This patient has done well and had a 150/90 mm. Hg pressure reading in March 1963.

It was the surgeon's belief that no significant arterial disease existed. Since a pressure gradient of 13 mm. Hg was measured, this patient's future course will be followed with interest in view of the number of patients Morris and his associates[3] reported with gradients less than 25 mm. Hg.

Case 4.—A 42 year old white man had intermittent claudication in both legs for about seven years and hypertension for one year. His femoral pulses could not be felt. He was admitted to Baptist Hospital in April 1963 with a blood pressure of 240/140 mm. Hg. An intravenous pyelogram showed a smaller left kidney with faint calyceal demonstration. A left brachial retrograde aortogram showed complete occlusion of the aorta just below the level of the renal arteries and two prominent stenotic lesions of the left renal artery. Numerous collateral vessels to the iliac arteries were visualized (fig. 4). A partial endarterectomy with an aortic bypass graft was performed. A bypass graft also was made to connect the aortic graft with the left renal artery distal to the stenosis. The femoral pulsation returned and the blood pressure has fluctuated between elevated and normal levels.

This patient demonstrated major arteriosclerotic disease in the aorta and a renal artery. His follow-up period has been too brief for full evaluation.

Case 5.—A 57 year old white woman had a history of hypertension for six months which had responded incompletely to medication. Her blood pressure was 200/100 mm. Hg on admission in May 1963. A left femoral pulse was not felt. Two excretory urographic studies were performed. The first one showed no function on the left side up to 10 minutes. The second study was a mannitol flush intravenous pyelogram in which no delay in function was seen. The late films following the flush showed a reversal of the contrast pattern from the early films with denser contrast material in the left kidney and also a smaller collecting system (fig. 5). A radiorenogram was interpreted as abnormal on the left side. A retrograde femoral aortogram showed bilateral renal artery stenosis with more prominent poststenotic dilatation on the left side (fig. 6). The abdominal aorta showed numerous plaques, and there was complete occlusion of the left iliac artery. An endarterectomy was performed on the right renal artery and a

bypass graft was employed to the left renal artery. A bypass graft was also used at the left iliac artery.

The discrepancy between the two urograms is interesting and the explanation is not apparent. In both studies, the films obtained up to 10 minutes were under dehydrated conditions. The infusion in the flush intravenous pyelogram begins after the 10 minute film. It is also of interest to note that bilateral renal artery stenosis was found while the preliminary tests pointed to unilateral disease.

Case 6.—A 20 year old white woman had a history of hypertension for six months with recent levels of 220/120 mm. Hg. She was admitted in June 1963 and a flush intravenous pyelogram showed delayed washout of the Hypaque in the right kidney. The right kidney was 1 cm. shorter than the left one. A percutaneous right femoral retrograde arteriogram showed a corrugated outline of the right renal artery which was interpreted as fibromuscular hyperplasia. Right renal artery surgery is being considered.

Comment

A few reports will be cited to demonstrate that substantial numbers of hypertensive patients with renal artery disease have greatly benefited from appropriate surgery. Morris and his associates[3] reported relief of hypertension in 80 per cent of 200 patients; the average follow-up period was 1.6 years. Poutasse[8] reported about 62 per cent relief of hypertension in 76 patients followed at least one to six years postoperatively. In this series, an additional 16 per cent showed significant reductions in pressure levels. Spencer and his associates[2] reported resultant normotension in 13 of 24 patients and there was only residual systolic hypertension in 10 more. Brown and his associates[9] submitted six patients to surgery with relief of hypertension in five of them. A number of other reports of successful renal artery surgery have also appeared in the literature.

In the series reported in this paper, renal artery reconstruction was performed in four of the five patients with a radiological diagnosis of arteriosclerotic renal artery stenosis. Relief of hypertension for varying periods occurred in two of these. The other two have been only recently operated upon. The sixth patient of this series has unilateral fibromuscular hyperplasia and corrective surgery is being anticipated.

Summary

Renal artery stenosis is a correctable cause of hypertension. A brief review of six cases is presented, demonstrating the feasibility of making this diagnosis in a general community hospital. The contribution of radiological procedures to the diagnosis of this group of diseases is discussed and mention is made of some surgical results.

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Combined Pyarthrosis, Meningitis and Septicemia Due to Hemophilus Influenzae, Type B

Report of Case

James M. San, M.D.
Tampa

In their review of the literature in 1938, going back to 1899, Weaver and Sherwood[1] collected 11 reports of single cases by various authors in which pyarthrosis, meningitis and septicemia due to Hemophilus influenzae were combined. All of these combined cases were in infants and all were fatal. Referring to all cases of arthritis due to H. influenzae which they had collected, these authors observed: "The most striking point of similarity noted in all three tables [patients with joint involvement] is the age of the patient, the oldest recorded being 23 months, with the exception of our case two, which was a 59 year old woman." They further concluded: "Hematogenous pyarthrosis due to influenza bacillus usually occurs in infants. It rarely occurs in adults. If not associated with influenzal meningitis, the prognosis as to life and function of the joint is excellent, but if so associated, the end result is death."

A search of the available literature since 1938 yielded only one case in which the three entities were combined. Joslin and Howard[2] described an eight month old male Negro with bilateral purulent arthritis of both elbows, on aspiration and culture showing H. influenzae type B. They also described and showed x-rays of destructive changes in adjacent metaphyses of the radii, which subsequently cleared. Roughness of the articular surfaces persisted, however. The child was treated successfully with Aureomycin, and this became the first recorded case of combined arthritis-meningitis in which the patient was saved.

The present case is similar to that of Joslin and Howard[2] except that chloramphenicol was used internally as the therapeutic agent. This child also recovered.

Report of Case

A white male infant, aged one year, was admitted to Tampa General Hospital on Dec. 20, 1962. For one week his temperature had been elevated daily up to 103 F., and there was some cough. The referring physician had seen him once, four days before admission, and had treated him with sulfonamide and tetracycline for an upper respiratory infection. The symptoms did not become alarming, however, until approximately 12 to 18 hours before admission. At that time the temperature began rising up to 105 F., marked swelling and pain developed in the legs and arms, and the baby seemed slightly unresponsive.

When he was first examined, the striking feature was the swelling of both elbows, the left ankle and the joint of the left great toe. He lay curled on his right side and screamed in obvious painful apprehension if any move was made toward these limbs. The swelling was diffuse, slightly warm, and, in the arms, involved a good bit of the adjacent upper and lower areas. The apices of the swellings over the left lateral malleolus and head of the



Fig. 1. — Roentgenogram of right arm. Note area of osteolysis in the proximal metaphysis of the humerus. This disappeared completely in subsequent views taken one month later.

first metatarsal were bruised in appearance and exquisitely tender to touch. In addition, three plus rigidity of the neck and positive Kernig's and Brudzinski's signs were present. There were no petechiae.

X-rays of the extremities showed obvious periarticular swelling of both elbows (fig. 1). Also, a definite area of osteolysis was noted in the proximal metaphysis of the right humerus, which subsequently disappeared in follow-up films.

The spinal fluid was murky in appearance, with 5,200 white blood cells, practically all polymorphonuclear leukocytes. Gram stain thereof showed fairly numerous pleomorphic gram-negative rods. The spinal fluid culture was positive for H. influenzae, type B. A blood culture, taken on the day of admission, using ordinary blood culture technique (aerobic broth method), grew this same organism after five days' incubation. Routine blood and urine studies were not unusual.

Initial treatment was chloramphenicol, 100 mg./Kg./24 hours, given intramuscularly every six hours. After four days, oral medication replaced the injections. Treatment lasted a total of 14 days.

The fever abated slowly over a period of seven days, and a gradual, concomitant improvement in the arthritis was noted clinically. At the end of this seven day period, minimal swelling only was present, but the bruised areas persisted, not disappearing until approximately two to three weeks later. The child was no longer in pain. A blood and spinal fluid culture taken at this time grew no organisms, and the spinal fluid was practically clear, except for 56 cells, all lymphocytes. At no time was it deemed necessary to drain any of the joints as they were responding well to medical treatment.

Recovery was complete. At the time of reporting, six months later, the child is well, and there are no residual changes.

Discussion

It could be argued that this condition does not represent a true septic arthritis since the proof of etiology is inferential, that is, occurring during the course of meningitis and septicemia proved by culture and remitting concomitantly with them. The similarity, however, to previously reported cases in this age group, in which septic arthritis was proved by direct culture of joints or at autopsy, is striking. Possibly this one case might influence others to attempt medical treatment of this type of pyarthrosis using chloramphenicol only. Gessner[3] reported a case of suppurative arthritis, treated in a "closed" manner with chloramphenicol, and with excellent results.

Summary

A case of combined pyarthrosis, meningitis and septicemia due to H. influenzae, type B, in a one year old white male infant is presented. Positive cultures were obtained from the spinal fluid and the blood. Typing was done with standard typing serums. No attempt at obtaining a direct culture from the joints was made, but the signs of pyarthrosis were so striking clinically, and so similar to those of previously reported cases, that it was inferentially assumed to be due to the same organism. Recovery was complete after treatment with chloramphenicol, 100 mg./Kg./24 hours initially. Treatment extended over a 14 day period.

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Dermatology

Localized Pigmentation of the Skin

Many discrete forms of darkening, congenital or acquired, appear on the skin, often creating problems of differential diagnosis. Melanin, blood pigment, bacterial or fungus products, and chemical or medicinal deposits are the causes of discoloration. Significant is the answer to the question: Does the pigmentation represent a localized lesion essentially of cosmetic concern or does it point to the possibility of serious dermatologic or systemic disorder?

Chloasma (melasma) appears as solitary or diffuse stains resembling giant freckles over the face, predominantly of women (fig. 1). It commonly accompanies gestation ("mask of pregnancy"), the pigmentation often disappearing after parturition. By the same endocrine mechanism it may intrude with the use of progestational oral contraceptives. Sunlight is a provocative factor. Chloasma may be present in systemic diseases such as lymphomas, "collagen diseases," hypothyroidism and hyperthyroidism, and nutritional disturbances. Often, however, no cause can be identified. It has nothing to do with disease of the liver.

Pigmentations are often seen in generalized neurofibromatosis (von Recklinghausen's disease). Here the condition occurs as multiple small freckles together with larger patches known as café au lait spots (fig. 2). In some cases these spots are present alone, with few or no tumors of the skin, as an abortive or incomplete form of von Recklinghausen's disease.

Occasionally a reaction of hypersensitivity to medication produces erythematous, sometimes bullous, plaques in certain areas of the skin, followed by hyperpigmentation (fig. 3). Every time the medication is taken the lesions recur in the same site (hence called "fixed"), and new ones may appear in other sites with the same property of flaring with the drug and subsiding when it is discontinued. Phenolphthalein is the outstanding cause of fixed drug eruptions, but other medicaments may do the same, such as barbiturates, sulfonamides, quinine, salicylates, and antibiotics.

Postinflammatory hyperpigmentation is temporary or permanent. It may follow trauma such as friction or burns, or dermatoses such as lichen planus, chronic intertrigo, neurodermatitis and contact dermatitis (fig. 4).

A photodermatitis indigenous to Florida is caused by contact with peel of the lime followed by exposure to the sun (fig. 5). Erythema occurs, often with blisters, to be later replaced by a brownish streaked or patchy hyperpigmentation on hands, forearms and face. It usually persists for several months. This is the same eruption, known as berloque dermatitis, which may appear with application of perfumes or colognes and exposure to sunlight.

Tinea nigra forms grayish or black spots on the palm of the hand. Caused by the fungus Cladosporium wernecki, it resembles a stain produced by silver nitrate (fig. 6). The disease assumes significance because it may be mistaken for a junction nevus. Treatment with any standard fungicidal preparation is promptly curative.

Prepared by the Committee on
Scientific Exhibits
Florida Society of Dermatology



Fig. 1.—Chloasma (melasma).



Fig. 2.—Generalized neurofibromatosis, showing café au lait spots.



Fig. 3.—Fixed drug eruption caused by barbiturates.



Fig. 4.—Hyperpigmentation following contact dermatitis due to rubber.



Fig. 5.—Photodermatitis caused by contact with peel of lime.



Fig. 6.—Tinea nigra of palm.

The courtesy of Lederle Laboratories, Division of American Cyanamid Company, is gratefully acknowledged.

A Slipped Strut From Stapedectomy

Report of Case

William F. Shipman, M.D.
Tallahassee

A case is reported in which a polyethylene strut over Gelfoam slipped following stapedectomy for otosclerosis. Aside from showing what trauma the cochlea can take, it is a reminder to those of our specialty as well as to those in general medicine of stapedectomy complications from successful surgery performed elsewhere. They may sporadically be encountered in one's office under the guise of Meniere's disease, cerebrovascular accidents or other conditions. This is conceivable in the rush of daily practice where there is negligence in questioning or the patient does not mention previous surgery. Precious time may be lost before the true situation is recognized, thereby lessening the amount of cochlear salvage that could be obtained from early revision.

Report of Case

A 38 year old white woman with preoperative air conduction of 45 decibels and normal bone conduction experienced an improvement up to 12 decibels following an apparently successful stapedectomy by a capable surgeon in another state. Three months later, she complained to her internist of vertigo, tinnitus and loss of hearing. He treated her with sedation and vasodilators as he did most of his patients with inner ear conditions. She finally mentioned the stapes surgery to him.

On examination, the Weber 500 fork lateralized to the unoperated ear. With a Barany noise maker in the unoperated ear she could understand speech, however, in the operated ear. Seiglescope movement of the ear drum of this ear produced positive symptoms of fistula. Caloric tests showed no signs of response at 30 cc. ice water in this ear with complications. Speech discrimination was 90 per cent. We assumed the cochlea was intact. Pure tone testing average for the three speech frequencies for air had dropped to 70 decibels with the bone conduction at 20 decibels.

With the suspicion of a slipped prosthesis, we called her surgeon, who stated that no such complication had occurred in his experience. We agreed to try medical treatment for a few more days consisting of daily histamine drips, nicotinic acid, sedation, vitamin B^{12}, steroids, enzymes, and complete bed rest. Three days later, the subjective symptoms were less and the air conduction had improved from 70 to 50 decibels and bone conduction from 20 to 10 decibels. With the intact cochlea and marked air-bone gap, the surgeon consented to explore. He found the strut perforated through the round window membrane and lying deep in the vestibule. Revision with a wire-fat graft provided dramatic relief of the symptoms with the hearing returning to normal at the original postoperative 12 decibel level for air.

One year later, the patient admits to excellent understanding and reception at normal speech levels with no handicap.

In this case revision was accomplished in 18 days, and the results are consistent with the findings of Steffen, House and Sheehy,[1] whereby in a majority of cases the patient receives useful improvement if revision takes place within 30 days of the onset of symptoms.

Read before the Florida Society of Ophthalmology and Otolaryngology, Scientific Session on Otolaryngology, Hollywood, May 18, 1963.

Reference

1. Steffen, T. N.; House, H. P., and Sheehy, J. L.: The Slipped Strut Problem; A Review of 52 Cases, Ann. Otol. Rhin. & Laryng. 72:191-205 (Mar.) 1963.

205 East College Avenue.

Comment

Robert J. Camp, M.D., Coral Gables: It has long been stated that only the physician and his patient are interested in his successes, while his colleagues are interested in his complications. The two cases submitted for publication by Dr. Shipman in this issue of The Journal, point this observation up to a fine degree. The one is a complication that can certainly happen to anyone doing stapes surgery, while the other, although not a true complication, shows an adequate handling of a very complicated problem.

It is only human nature to commiserate with the persons involved in these cases, but it also gives one a warm feeling deep inside that he himself is not directly concerned.

It is certainly a truer measure of a man's ability to observe how he stands up to his complications with equanimity, than how he accepts his successes, and it takes a certain amount of commendable confidence to air these complications for his colleagues to see.

The Effect of Medical Assistance for the Aged on Tax-Supported Health Care in Florida

H. Phillip Hampton, M.D.
Tampa

The Florida legislature has created a program of medical assistance for aged Florida residents which began operation on July 1 of this year. Benefits are limited to hospital care for acute illness or injury and to home nursing care following hospitalization.

This legislation is in accordance with federal law known as the Kerr-Mills Act which provides federal funds to reimburse states partially for expenditures made in providing health services of any type to the aged needy sick. With certain limitations the state defines the extent of benefits and criteria for eligibility. The percentage reimbursement available to Florida is 60 per cent.

For this biennium, $3,000,000 of state funds was appropriated for Medical Assistance for the Aged (MAA) and, for this amount, $4,500,000 in federal reimbursement will be available, providing a total of $7,500,000 for the two year program.

This program will provide two things:

(1) Better health services will be more uniformly available to aged needy sick throughout the state.

(2) Some relief will be provided counties in defraying the costs of tax-supported health services.

Since 1956, Florida has had a program of hospital care for the needy sick of all ages financed by a state and county matching fund administered by the State Board of Health which has paid hospitals their actual costs for hospitalization of indigent persons. Sixty-three counties have voluntarily participated in this plan.

The legislation creating this program was based on recommendations made by a citizens committee appointed by Governor Collins to study problems of medical care available to indigent persons. The committee found great variation in medical services available to indigents in the 67 counties.

Often hospitals were required to absorb all or part of the costs of indigent hospitalization and pass on the cost by increased rates for the paying patient, or in effect imposing a sickness tax. There was a tendency to create all charity hospitals in each county which usually provided inadequate facilities and stayed filled with patients who remained in the hospital for unreasonably long periods of time. Often the result was a high cost to the taxpayer for inferior services rendered the indigent. The committee recommendation was a state and county matching fund to pay the costs of needed hospital care anywhere in the state for any certified indigent.

The state appropriation for this plan has never been adequate and the fund has not been sufficient to pay for more than a fourth of the hospital care given, but it provided some relief to the counties and established a new pattern of tax-supported hospital care.

In 1959, the costs of hospital care provided Public Assistance Recipients began to be paid from state and federal funds, and counties were relieved of this expenditure for that category of the indigent.

For the past three years, the counties of Florida have expended annually a total of about $23,000,000 of tax funds providing health services of all types for the needy sick of all ages. About one third of this amount has been spent for those 65 years of age and over. The new Medical Assistance for the Aged program should relieve the counties of expenditures for acute hospitalization and home nursing care for those in need of help who are 65 years of age and over.

For the purpose of comparison, table 1 presents the tax-supported expenditures for health

Chairman, Advisory Committee on Hospital Service for the Indigent and Medical Assistance for the Aged, Florida State Board of Health; Chairman, Council on Legislation and Public Agencies, Florida Medical Association.

Presented at the Annual Convention of the State Association of County Commissioners, Hollywood, Oct. 2, 1963.

Table 1.—Tax-Supported Expenditures for Health Care in Florida

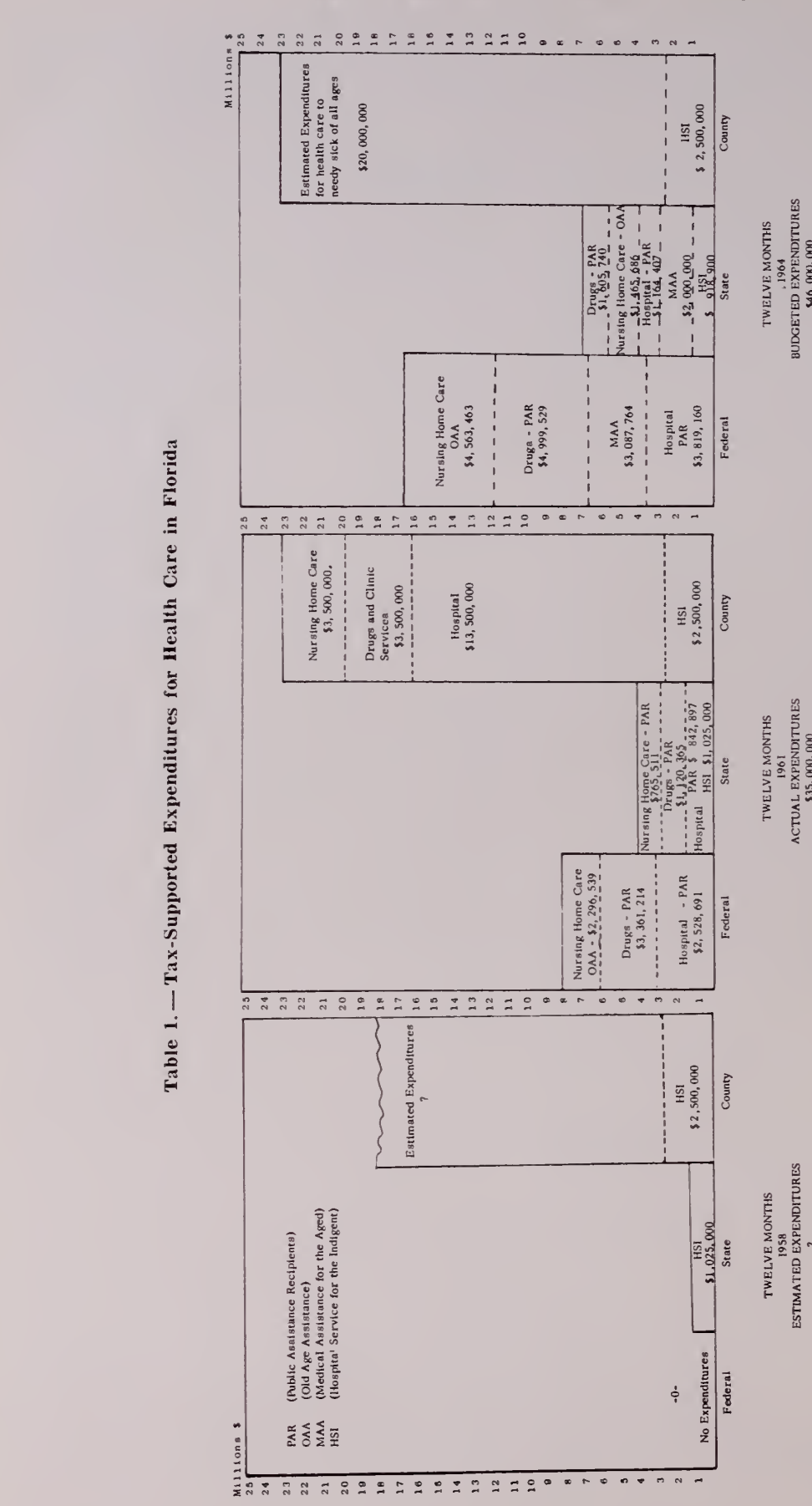


Table 2. — Budgeted Tax Funds For Health Services to Needy Sick in Florida

Biennium 1963-1965

Service	Federal	State	County	Total
Drugs PAR	$ 9,829,759	$ 3,157,195	$ 0	$12,986,954
Nursing Home OAA	8,633,229	2,772,807	0	11,406,036
Hospital				
PAR	7,478,042	2,283,297	0	9,761,339
MAA	4,881,646	3,250,000	0	8,131,646
HSI	0	1,808,800	5,158,000	6,966,800
				49,252,775
County expenditures for additional health services to needy sick, estimated from past two years experience			40,000,000	40,000,000
Total	$30,822,676	$13,272,099	$45,158,000	$89,252,775

care in Florida as estimated for 1958, actually expended in 1961 and budgeted for 1964. Table 2 tabulates the budgeted amounts for the biennium 1963-1965.

About $25,000,000 is budgeted to be spent for hospital care in this biennium through the programs of Hospital Service for the Indigent, Medical Assistance for the Aged, and hospital care for Public Assistance Recipients. The advisory committee for these programs is composed of two doctors of medicine, two hospital administrators, one discreet citizen, two county commissioners, and two members of the legislature. Our meetings with the staff members of the Florida Department of Public Welfare and the Florida State Board of Health provide opportunity for the cooperative approach of several state agencies and nongovernmental associations necessary for the successful operation of tax-supported health care programs.

The purpose and effect of the Kerr-Mills law and the Medical Assistance for the Aged program are to provide federal funds in aid to the states and counties in fulfilling their traditional and constitutional responsibilities of "providing for those of the inhabitants who by reason of age, infirmity, or misfortune may have claims upon the aid and sympathy of society." (Florida State Constitution Article XIII Section III)

This principle of parish or county responsibility to provide for those who may be in need of aid was established in England during the time of Elizabeth I and adopted in the state constitutions of most of the United States. Especially in the urban and industrial areas, this responsibility has become an increasing tax burden, and as other tax sources have been claimed by state and federal government, the ad valorem taxpayer has been hard pressed to foot the tax-supported health care bill.

The principle of using federal funds to aid states in welfare programs was established during the great depression. In 1936 the Florida constitution was amended to permit ". . . the Legislature . . . by general law (to) provide for a uniform statewide system of such benefits . . . in order for the State of Florida to participate in any Federal Grants that might be made for such purposes...." (Article XIII Section III) Therefore, the state and federal laws providing the program of Medical Assistance for the Aged have established no new principles of government.

One would be less than realistic to believe that adequate and acceptable programs of health services for those in need could be provided by tax sources available to the counties today and more than naive to think the use of federal funds did not pose a threat to the responsibility and rights of the states. The alternative, however, is a federally administered system of health services supported by the social security tax which would provide neither better nor more economical health care for either the indigent or taxpayer, but would be a major irrevocable step in the direction of a socialist government. The ultimate solution to this problem, in my opinion, lies in a readjustment in our tax structure and not a readjustment in our principles of government.

Actually the number of aged requiring tax supported assistance in paying for needed hospital care has diminished in Florida during the past

three years. This trend will continue, and the need for indigent hospitalization programs will diminish as voluntary health insurance and pension plans including health insurance increase.

Medical Assistance for the Aged should act in the manner of major medical insurance but with a variable deductible. That is, an aged person would not be eligible for tax-paid health services until he has used his own resources (above those required for basic needs) to pay for needed care, but tax-paid health care will be available to insure against his having to expend for medical care those funds needed for the necessities of life. Unfortunately, our present regulations do not comply with this definition of eligibility as worded in the state law, and I hope we can remedy this inequity in eligibility soon.

We must, of course, trim the program to keep expenditures within the state appropriation. In the past two years, however, the counties of Florida have spent better than $15,000,000 in providing health services for needy sick 65 years of age and over. In the next biennium they stand to be relieved of about half this expenditure through the existing Medical Assistance for the Aged program.

The major expenses have been in the 11 largest counties over 100,000 population. If these counties would agree to a joint plan, it would be possible to obtain 60 per cent federal reimbursement, without increased state appropriation, for the other half of the expenditures for the aged sick which the counties are now wholly supporting.

Summary

In summary, therefore, the present Medical Assistance for the Aged in Florida will provide up to 30 days of hospital care and subsequent home nursing care for Florida residents 65 years of age and over who have monthly incomes of less than $150, savings of less than $1,200, and no property other than a homestead. State and federal funds totalling $7,500,000 are available to provide these services during the next two years.

I hope the eligibility regulations can be changed to comply with the law so as to provide such services to those aged whose resources have been reduced by incurred or immediately anticipated medical expenses to the extent that they would not have sufficient funds for the necessities of life as determined by the Department of Welfare.

I hope we can provide outpatient care as part of the hospital care so as to cut down on costly inpatient hospital care and I hope this can be provided by 60 per cent federal reimbursement of expenditures now being made by the counties.

Finally, I hope the Congress will amend the Kerr-Mills Act to permit Medical Assistance for the Aged plans to participate with eligible aged in payment of premiums for acceptable health care insurance and thereby encourage self reliance and obviate the necessity of welfare investigation at the time of illness.

In this manner, states and counties can provide for the needy in accordance with their constitutional responsibility with the hope of rehabilitation of the recipient to self reliance.

Ultimately, I hope, after we have gained more experience and determined the cost, we can swap the federal grant-in-aid to Florida for one of the federal taxes imposed on the people of Florida. Frankly, I expect this ultimate hope may be achieved just this side of the millennium, but there is no faith in charity without hope.

Metamucil

It has been said that Mother Nature is a veritable storehouse of untapped remedies. Of course, medicine has utilized a number of natural products—as an example, the "silly" psyllium seed in the bulk laxatives. See page 181.

Problems in Providing Nonsurgical Health Insurance for Young and Old

Alan M. Thaler
Newark, N. J.

The Health Insurance Council

I am speaking to you today as a representative of the Health Insurance Council. I am sure that some of you have already had contacts with the Florida State Committee of the Health Insurance Council. I would like to tell you just a little about the Council and its activities at the national and state levels so that you can better understand what I represent and the context of some of the remarks that I shall make.

The insurance business is no different than other businesses in that there are a great many different associations within it which are designed to cater to the special needs of its various segments. When the health insurance business began to develop in the '40s, it was realized that there was no single group to speak for the insurance business in connection with its relations with doctors, hospitals and others concerned with health services. As a result, there was formed for this purpose a federation of the various insurance associations, and it was called the Health Insurance Council. The Council operates through a number of committees. The committee members consist of insurance company executives from all parts of the country, and it is the function of these committees to find the answers to the many practical problems which confront the health insurance business in its relations with doctors, hospitals and other providers of health services.

To illustrate the work of the Health Insurance Council, I might mention two important accomplishments which it has worked hard to achieve. One has been the development of uniform hospital and medical report forms. I am sure that most of you in this room have many times deplored the time required in the completion of insurance company forms and the great variety of such forms that come across your desk. As a result of the efforts of the Health Insurance Council, insurance companies have done much to simplify and standardize their forms. The standardized forms were developed by the Council in consultation with, and have the approval of, the Council on Medical Service of the American Medical Association. Another important accomplishment has been the development of hospital admissions plans which simplify the hospital admissions requirements for persons with various forms of health insurance. In the last few years, the Health Insurance Council has encouraged the development of State Committees of the Council, and the Committee in the State of Florida is a very active one.

The Insurance Mechanism

Whenever we consider the problems of health insurance, it is desirable to review some of the basic principles. The most important single factor which must be remembered is that the insurance mechanism does not of itself create any new money. Persons who purchase insurance are still paying for their health care in the same way as a person who does not have health insurance. They have merely made certain arrangements that permit the averaging of these costs with other persons. It follows, therefore, that if persons who have health insurance are unnecessarily confined in a hospital, have unneeded diagnostic procedures or incur unusually high medical bills, these costs will in due course be reflected in the cost of premiums that the individual pays for his insurance. When this happens, a person who is paying for the insurance may decide that the price is too high and may request lower benefits or may decide to terminate the insurance.

Very often the insurance business is criticized because a plan of insurance does not conform precisely to medical practice or because the benefit payments may not make proper allowance for the skill and training of a specialty group. When you encounter such a situation, I hope you will not place the entire blame on the insurance business. Most insurance companies today do make available policies with very broad benefits. You can understand that the broader the benefits—the higher the premiums must be. To date, most

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Read before the Florida Society of Internal Medicine, Hollywood, May 18, 1963.

of the buying public has purchased lower-priced products which are also made available by the insurance business, and this of necessity means correspondingly reduced benefits. Insurance companies have operated under the philosophy that it is better to provide insurance against some of the hazards and against part of the total cost rather than not to provide the insurance at all. We have been struggling with this economic problem for a long time. We can only provide what people are willing to pay for. We have been making real progress, however, in developing the taste of the public for better benefits. I would like to tell you about some of the progress that is being made and about some of the problems that are being faced as a result.

The Growth of Health Insurance

It is commonly assumed that the insurance business can easily influence the nature and extent of health insurance benefits being purchased by the public. Certainly the insurance business can influence these buying habits, but it is not easy. As I have already indicated, the consumer is concerned with the cost of what he is buying and has preconceived ideas on how much he should spend. Also, as I shall explain as we proceed, the buying public, of which an important segment is employers and unions, has preconceived ideas on the kind of benefits it wishes to purchase.

The growth of health insurance in the United States did not really get under way until the end of the '30s. The rapid development of Blue Cross-Blue Shield plans across the nation at that time set the pattern for hospital and surgical coverage, and the insurance industry joined in filling this demand. It was not until the late '40s that there was any extensive departure from this pattern through the sale of benefits for diagnostic care and for medical services in the home and doctor's office. As you know, group insurance as distinguished from individual policies played by far the most significant part along with Blue Cross and Blue Shield in the rapid growth of health insurance. To a large extent, the benefits sold were the result of collective bargaining agreements between employers and unions. As a result of these influences, the extent of hospital coverage grew by 1950 to the point where 76 million people were covered for hospital expense insurance, 54 million for surgical insurance—but only 21 million were covered for a rather limited form of nonsurgical medical expense insurance.

It was about that time that the insurance industry began to develop an awareness of the fact that the health insurance which was being sold was aimed at covering much too limited a portion of the total medical care needs of an individual, that it was directed too much towards providing insurance against the smaller more easily budgeted expenses, and that there remained an important unfilled need to insure against the more dramatic expenses of a long illness and against nonsurgical medical care.

The Development of Major Medical Expense Insurance

The result of this self examination was the development of a new health insurance plan which was called Major Medical Expense insurance. This differed from the traditional health insurance, which has been offered by insurance companies, in several important respects. First, it did not limit coverage only to certain limited and specified types of medical care, but rather encompassed the full spectrum of usual medical treatment. Secondly, it was directed towards protecting the individual against severe illness, and a maximum benefit of $5,000 or $10,000 was provided. Thirdly, it had to recognize the fact that the cost of an all-inclusive coverage would be beyond the reach of most insurance buyers and that some compromise was necessary. For the purpose, therefore, of controlling premium cost, there was introduced the concepts of a deductible amount and of coinsurance. The deductible was designed to eliminate the less costly illnesses which the insured could take care of himself. The coinsurance idea was intended to give the insured a continuing interest in the nature, extent and cost of the medical services that he obtained. Usually under a Major Medical plan, the policy will pay 75 per cent or 80 per cent of the insured's expenses above the deductible amount. The 20 per cent or 25 per cent which the insured pays himself is the portion which is co-insured.

Major Medical policies of the type I have just described first became available in 1951. Many of us anticipated that the growth of this new form of coverage would be rapid, but instead it was disappointing to find that our progress in winning acceptance for Major Medical Expense insurance was slow. It was not until 1954 or 1955 that the insurance industry began making any sizable inroads into the market for this form of coverage. Even at that time and to this very day, this progress has been made not on the basis of

presenting this as a completely new product but essentially on the basis of selling this form of coverage in conjunction with first dollar hospital and surgical benefits. By "first dollar" benefits I mean benefits which are payable without the imposition of a deductible amount, for example, from the first day of hospital confinement. In other words, most plans sold today still provide for some so-called first dollar coverage for hospital and surgical expenses. The deductible and coinsurance features of the more comprehensive Major Medical Expense insurance usually apply only to the balance of the plan. Ideally, the same deductible and coinsurance percentage should apply to all types of medical services, including hospitalization. Then there would be no incentive to put people in the hospital for those tests physicians can perform in their own offices. The fact that these first dollar benefits for hospital and surgical expenses are still so prevalent is proof of how tenaciously the public has preserved its purchasing habits acquired in the late '30s and early '40s. Nevertheless, real progress has been made in the growth of Major Medical Expense insurance and this form of coverage has been increasing each year at a faster rate so that today we have roughly 40 million people who are protected by Major Medical Expense insurance.

Problems Arising from Major Medical Expense Insurance

While the introduction of Major Medical and its rapid growth have been a big step forward in providing adequate health insurance coverage, especially in the nonsurgical area, it has brought to the fore problems which previously the insurance industry was not required to face. Before the advent of Major Medical, most health insurance policies provided for the payment of stated benefits for each day of confinement in a hospital and stated benefits for each surgical procedure or for each visit to a doctor's office. The benefits were set generally not in excess of the going rates, and if an insured incurred a loss, there was little or no question as to the amount to which he was entitled under the policy. Major Medical policies on the contrary do not generally contain these fixed dollar limits. Most such policies do, however, contain provisions which state that benefits will be paid only for *necessary* care and treatment of the insured and also provide that only those charges which are at the *usual and customary* level will be recognized as eligible under the policy. You can readily understand that this kind of policy language presents some real administrative problems for an insurance company. Insurance companies readily enough came to the conclusion that it was both important and desirable to include such control provisions in Major Medical Expense insurance. To go about administering these provisions, however, in a fair and equitable manner has not been such an easy matter.

Most claims for benefits under Major Medical policies today can be processed in routine fashion. It is generally clear from the nature of the disability and the treatment that the services performed were necessary, and in the vast majority of situations the insurance carrier finds that the charges for the necessary services are within the "usual and customary" concept of the policy. This is not true of all claims, however, and when the study of a claim indicates possible overtreatment or what may appear to be excessive charges, the matter must be explored and resolved. Most insurance companies have gained a great deal of experience in dealing with this type of problem in the last few years. If a claim is made and the charges appear high to the insurance company, the company will attempt to appraise it with all of the facts available to them—taking into account such factors as the special skills and training of the physician, the level of charges in the immediate area, the income of the insured, the severity and difficulty of the case, and other factors. In many cases, by reviewing these facts or through a discussion with the physician, the claim can be satisfactorily settled. One basic point must be understood—if Major Medical Expense insurance is to continue to work satisfactorily—the physician should not use the existence of the insurance as one of the criteria in the setting of his fees. If this is done, the result will be to raise the cost of medical care for the insured population above that of the uninsured, and on that basis voluntary insurance may not survive.

In some claim situations, there is a bona fide difference of opinion or some question which cannot be easily resolved, and for use in this type of situation, a relatively new mechanism has been developed. I am now referring to the Review Committee procedure which has been developed in many parts of the country including Florida. As in your situation in Florida, these committees are organized by the Medical Society at the county level in cooperation with the State Society. The Review Committee consists of a group of

doctors who give objective and impartial advice to insurers as well as physicians. The State Committees of the Health Insurance Council are glad to provide technical advice and assistance in connection with the establishment of such Committees. If an insurance company has difficulty in making a determination on a claim involving a physician's charges, it may seek the advice of the Review Committee. Likewise, if the doctor is not satisfied with the way the insurance company has resolved a problem relating to his charges, he may in turn refer the matter to the Review Committee. These procedures are working well. In 1961 the House of Delegates of the American Medical Association gave recognition to these problems resulting from health insurance and adopted a recommendation encouraging each state medical association to develop and administer Review and Utilization Committees. Perhaps more than anything else that is being gained from the operation of these committees is a better understanding on the part of the insurance industry of the doctor's problems and conversely a better understanding on the part of the doctor of the problems relating to the cost and administration of insurance.

Problems of Insuring the Aged

When Dr. Butler wrote to me, he indicated special interest in the problems of insuring our senior citizens. You may very well ask if voluntary health insurance has made such dramatic progress starting from a point of almost no coverage to the point where there are today over 140 million people who have some form of protection and over 100 million of these with coverage for nonsurgical physician's visits—why should there still be such an important problem existing among our senior citizens? In looking at this problem, it should be kept in mind that the greatest portion of the growth of health insurance has been under group type plans where persons have been covered in connection with their employment. The emphasis has been on developing and expanding these plans for the working force. It has only been within the past 10 years that attention has been focused on the problem of continuing these benefits beyond retirement. Many employers are today providing such continuation of coverage, but again it has taken time to educate all concerned to the need for this protection to the point that they are willing to pay the costs that go with these benefits.

It should be realized that an older person becomes ill more frequently and for longer durations with the result that the annual cost of providing health insurance for such a person may be from two to four times that of providing coverage for the younger active members of a group.

In spite of the slow start that was made in tackling this problem of providing coverage for retired persons, remarkable progress has been made in the past 10 years. Currently, there are over 10 million people in the United States age 65 and over with some form of private health insurance coverage. This represents 60 per cent of the total noninstitutionalized aged population. As an indication of the progress that has been made, this figure should be compared with a figure of about three million persons covered 10 years earlier. The insurance industry has been tackling this problem of providing coverage for the aged with increasing vigor, and there seems little doubt but that the problem of providing coverage for this segment of our population on a voluntary basis will, to a great extent, be taken care of within the next few years if action by the federal government does not intervene.

Coverages Being Offered the Aged Today

Perhaps you would like a quick summary of what is being done today in this area of coverage. First of all, we have the coverage provided by Blue Cross-Blue Shield. Blue Cross-Blue Shield has consistently made it a practice to provide continuation of coverage on older persons and now, in addition, offer individual enrollment plans for the aged. There are today over five million persons age 65 and over covered under Blue Cross plans. Of these, over three million persons have Blue Shield coverage.

Also, there are those persons who have continued to be covered under group health insurance policies following retirement. This is an increasingly important area of coverage, and the breadth of this coverage is becoming greater. A significant number of group plans now provide for the continuation of Major Medical benefits into retirement. Many other group plans which do not provide as yet for a continuation of benefits contain a conversion privilege which permits a person to purchase without evidence of insurability an individual policy at retirement.

Next, we have the individual health insurance policies being offered to senior citizens by a large number of insurance companies. Again we find

the pattern of the development of the health insurance business has been repeated here. By far the bulk of the coverage that has been offered to senior citizens until now under these individual policies has been hospital-surgical expense insurance. A long list of companies offers these plans on an individually underwritten basis. A few companies have, however, experimented with a mass marketing technique under which during certain open enrollment periods all persons age 65 or over are permitted to enroll and become insured subject only to a relatively short waiting period on any pre-existing conditions. This technique has been a valuable step forward in extending insurance protection to senior citizens who might otherwise find themselves to be uninsurable.

Within the last year or two, there have, however, been some most interesting developments in providing Major Medical type coverage for these older people using the mass marketing technique already mentioned. Experimentation with this type of plan has gone forward not only on the basis of the offerings of certain individual companies but also on the basis of certain state plans in which a number of insurers have joined in underwriting this type of benefit. In this last connection, Connecticut insurance companies led the way in 1961 with the formation of the Associated Connecticut Health Insurance Companies. All the residents of Connecticut 65 years or older were given an opportunity to enroll under this plan. The plan was highly publicized in newspapers, on television and on the radio. During the first open enrollment period, which was held in September of 1961, approximately 22,000 of the estimated 240,000 over 65 enrolled under the plan. Additional enrollment periods held since then have added about 8,000 to the plan. Those enrolling were offered four options. Each of these options contained Major Medical Expense benefits. Two of the four options also included basic hospital and surgical benefits. The Major Medical provisions of the plan include benefits for doctors' calls, drugs, diagnostic services, private duty nursing care and certain convalescent nursing home benefits. The cost of the most liberal plan providing $10,000 Major Medical plus a plan of basic hospital-surgical benefits was $17 a month.

The idea of this plan spread to New York and Massachusetts the following year. Legislation authorizing the offering of such a plan was passed in both of these states, and last fall plans were offered in both New York and Massachusetts. In New York, during the first open enrollment period, which was held last October, 107,000 out of approximately 1,700,000 elderly persons enrolled. In Massachusetts, approximately 50,000 enrollments out of an estimated 570,000 were obtained. At the present time, the creation of similar plans in other states is under study. It is still much too early to evaluate the success of these plans, but it is clear that an important contribution has been made by the participating insurance companies in making this broad form of health insurance coverage available to this segment of the population. It would seem that the availability of such plans and coverage does much towards putting within reach of persons over 65 both basic and Major Medical coverage.

The Role of Government

We may well ask, if voluntary health insurance is making these important steps forward in covering the aged—in improving the scope and extent of insurance—what then should be the role of the federal government in filling this need? The answer is that if the government will give voluntary insurance a little more time, free enterprise will get the job done in good fashion for all those who can afford to pay for insurance. For those who cannot afford to pay their medical bills or purchase insurance, there are already two governmental mechanisms for taking care of this problem. One is the Old Age Assistance program for the indigent. The other is the Medical Assistance for the Aged program under the more recent Kerr-Mills Act which enables individual states with the help of matching federal funds to set up medical benefit programs for those persons not under Old Age Assistance but who, nevertheless, require medical assistance. This makes provision for the only other group which seems in need of medical care and unable to pay for it.

A number of states have taken action to implement provisions of the Kerr-Mills law. It takes money at the state level, however, to effect this implementation. An increasing number of states are taking action. At this point of time, 32 states have taken advantage of the Kerr-Mills law to make provision for Medical Assistance for the Aged benefits to the medically indigent. At the present time, 14 per cent of the over 65 population are eligible for benefits under the programs of Old Age Assistance or Medical Assistance for the Aged. This 14 per cent, when added to the 60 per cent covered by some form of voluntary health

insurance, gives the impressive total of 74 per cent. It would, therefore, seem that with the progress being made under the Kerr-Mills law, plus the continued advances of voluntary health insurance, any case which can be made for a need for further federal intervention in the form of a medicare program is a rapidly disappearing one.

A Look at the Future

Having devoted this amount of time to a discussion of the growth of health insurance and to the problems that exist today, I cannot resist a little speculation on what the future holds. When I look at the progress that has been made in the last few years in broadening the scope of benefits —in extending coverage to the aged and uninsurable—in improved understanding and relations between doctors, hospitals and the insurance industry, I cannot help but feel an overwhelming sense of optimism as to the continued progress that will be made. Health insurance will continue to move in the direction of providing more comprehensive coverage and more and more we will see it expanding into the field of diagnostic and preventive care, as well as home care and treatment in the nursing home. I think we will continue to see a diminishment in the relative popularity of the narrower forms of health insurance which are limited to in-hospital and surgical benefits. In making these predictions, I do not mean to speak in any disparaging way of these basic coverages, for they have been the building blocks upon which the voluntary health insurance system has been built.

These improvements to which I look forward will not come about, however, without a continued uphill struggle to solve the many problems which still confront us. Many of those important problems—those dealing with overutilization and the provision of high quality medical care at reasonable cost to the public—are problems which we will have to work together to solve. These are problems which together, I am sure, we can and will solve.

Woman's Auxiliary

Florida Auxiliary Medical Education Fund

This fund was started in 1950 and has served many students in many communities. The purpose is to assist students in obtaining training in any of the allied medical careers. Any county auxiliary may borrow from the state fund for a worthwhile student. The repayment is due one year after graduation, giving the student time to find employment.

Up to now the fund has predominantly helped nursing students. This year Duval County Auxiliary transacted a loan to a student in the College of Pharmacy at the University of Florida. We were very happy for this opportunity as its broadens our usefulness in the whole field of medicine and allied sciences. This is a first in other ways also: to an advanced student, and to a man.

Some county auxiliaries have loan funds for their own students. This is a worthy project since it makes for a more personal approach. Dade County has helped hundreds of students and are very interested in "their girls."

Hillsborough County Auxiliary has recently set up a fund for grants. This is with the cooperation of the Gordon Keller School of Nursing whose Director contacts the auxiliary when a second or third year student would otherwise have to terminate her career.

Through this loan fund the Medical Auxiliary is endeavoring to assist the doctors in perpetuating the high ideals of the profession.

Mrs. Kenneth Weiler, Chairman
Florida Auxiliary Medical Education Fund

President's Page

Democracy In Action

God grant me the serenity to accept
The things I cannot change,
Courage, to change the things I can,
And wisdom, to know the difference.
Prayer by Dr. Reinhold Niebuhr
(1935)

Unlike the slogan advertised by a national oil company, we are unable to say: "Not a speck of trouble." But we can paraphrase the sentiment expressed in the same advertisement to remark that the public expects more from Florida physicians, and they get it.

At Orlando, where the Sixth Annual Conference of Presidents and Secretaries of county societies comprising the Florida Medical Association met in late January, we found many topics of disagreement. Representing 28 societies and more than 95 per cent of the membership in the state, there were 130 registrants for the meeting. The agenda included national and state legislative programs, indigent care and medical services, and a panel on medical economics, in addition to a broad consideration of insurance and investment plans sponsored by the Association. Our honored guest, Dr. Ernest B. Howard, Assistant Executive Vice President of the American Medical Association, brought a message of encouragement in his inimitable way. He gave a synopsis of progressive changes in American medicine, as interpreted by the American Medical Association Board of Trustees, and emphasized their relationship to the practice of our profession, outlining proposals of action to combat difficult problems.

A good portion of the program was devoted to free round table discussion of problems encountered by county medical society presidents and secretaries. This provided an opportunity for exchange of ideas and for the presentation of novel approaches to the solution of difficulties encountered here and there in our state programs. By discussion, after clear presentation of the various difficulties, a certain meeting of minds occurred. The method seems to be a good one for clarification of many misunderstandings.

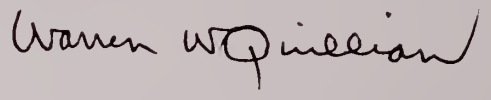
This brings us to an important fact so frequently overlooked. Each participant and every member of the Association attending such conferences is busy in the particular phase of Medicine which occupies his time and thoughts at home. Yet all of them, leaders in their respective county societies and communities, give freely and voluntarily of their time and talents for the betterment of the profession in Florida. By reason of this devoted service a great, constructive contribution is made.

Throughout the year there are many scheduled Council and Committee meetings. In preparation for this administration, it was most heartening to receive the many expressions, from our members, of eagerness and desire to serve Medicine in various capacities within the state. The loyalty and devotion of so many Committee members during 1963-1964 indicates the sincerity of those expressions. We have a wonderful organizational setup, an excellent executive staff, and a general awareness

that there is a job to be done. The policies and programs of the Association originate and are implemented by its Councils and Committees. More than 60 Committees are grouped into 10 Councils, providing for close cooperation and coordinated effort. Since standing Committees, through their respective Councils, report to the Board of Governors by way of the Executive Committee, each member has an opportunity to help with any action or policy for the benefit of the Association as a whole. The Board, in turn, reports to the House of Delegates. And, conversely, actions, requests or directives from the House of Delegates, Board of Governors or Officers are sent to the appropriate Council or Committee for study or implementation. All policy, then, should be representative of the entire membership, if considered and approved through the democratic processes which are provided.

The importance and responsibility of Committees cannot be overemphasized. Much of our progress during recent years has been the result of effective utilization of ideas springing from the enthusiasm and dedicated effort of our Committee members. And the fine thing is that each individual can be heard, making his contribution as a member, but through proper channels.

Perhaps, at times, an honest mistake has been made. But the mechanism is provided in our organizational structure to correct errors when they are recognized. In order to achieve our objectives and goals we must present a united front, but constantly be alert to the possibilities for improvement. Responsibilities and challenges may be accepted and met more capably with the accompanying realization that they offer opportunities for service. Service beyond the call of duty has been characteristic of Florida physicians in their generous contributions to civic enterprise, public health, medical education and organized medicine. Objective evaluation of the progress and accomplishments in all of these fields throughout the state indicate that the people expect and demand more from us than others. And it is my sincere belief that they are getting it.





Editorials

What Are We Doing for the Cuban Refugee Doctors?

The Cuban refugee medical doctors have been with us about three years now, some even longer. At first there was general confusion among the local medical group, the Cubans themselves, the federal, state and local governments, and the state and national medical associations. Gradually the problem has been lessened but, of course, has not been solved to the satisfaction of all parties concerned.

First, the problem was about 1,200 to 1,400 Cuban physicians who found it necessary to leave Cuba on short notice, many times with no funds and with only the clothes they were wearing. Some had no legal proof that they were doctors. The Department of Health, Education, and Welfare of the federal government assumed the responsibility of feeding, housing and clothing them.

The second problem was that these doctors wanted to go to work and could think of no good reason why they should not be allowed to start practice here. Our Medical Practice Act requires citizenship. It also requires a permanent certificate from the Educational Council for Foreign Medical Graduates and a year of approved internship in this country. People entering this country as refugees are not eligible for citizenship until their status is changed. So, for at least five years they cannot become citizens. Also, foreign graduates cannot come to this country for intern and residency training until they are approved by the Educational Council for Foreign Medical Graduates. None of these doctors had such approval and most of them were unprepared to stand this examination.

The School of Medicine of the University of Miami established a three month refresher course, which was financed by various grants, to prepare these Cuban physicians for the Educational Council's examination. A number in each class were unable to support themselves while taking the course; so the American Medical Association set up a loan fund for living expenses while the doctor was going to school. About 1,000 of these physicians have obtained a permanent certificate from the Educational Council after taking the refresher course.

So, in preparing the Cuban physicians for practice in the United States, we have:

1. Made it possible for them to live.
2. Made it possible for them to take the refresher course without charge, which assisted them in getting Council certificates.
3. Given them employment in the medical schools as associate professors.
4. Made it possible for them to obtain positions in the various hospitals as house doctors.
5. Helped them obtain recognized residencies for further specialty training.
6. Helped them to obtain employment in other states, in state institutions, and to become licensed in those states which do not require citizenship.
7. Many doctors furnished temporary housing and support for some until employment could be obtained.
8. The American Medical Association contributed to the support of the Cuban Medical Association in Exile for several years.

Most of these Cuban doctors are cooperative and try to abide by our rules and regulations, but there are some who are aided and abetted by some of our licensed doctors in practicing illegally. This we deplore and are making every effort to stop.

The situation continues to be a problem both to us and to the Cubans. It is our opinion that the most of these physicians are with us permanently, but as the years go by they can become citizens and become licensed.

Homer L. Pearson, M.D., Director
Florida State Board of Medical Examiners

A Cervical Cancer Cytology Survey in Florida

Women receiving aid to dependent children (ADC) have been found to be a high risk group for cervical cancer. This fact was proved in a three year Community Cancer Demonstration Project that covered 19 counties in Florida. The study, sponsored by the Florida State Board of Health, in cooperation with the Florida Department of Public Welfare, began screening patients in the ADC category for cervical cancer in June 1960. Since that time 10,174 women have been screened. At the closing date of the program, July 12, 1963, the cervical cancer cytology survey team had examined about 57 per cent of the available ADC population.

Out of the 10,174 women screened, a total of 411 women were found by the Papanicolaou technique to have abnormal cytology (Pap III, IV or V), which is 4 per cent of the women examined.

Cervical cancers proved by biopsy and found as a result of this screening operation numbered 199, for a rate of 19 per thousand women examined. This rate is considerably higher than most rates reported for general population studies. Eighty per cent of the cervical cancers found were in the in situ stage and 20 per cent were in the invasive stage. Women who were known to have had cancer were not included in this study.

It was found that of this high risk group of women on ADC only a few had previously had "Pap smears." In most instances they had not been exposed to health information on the subject of cervical cancer or "Pap smears."

Women found to have abnormal cytology (Pap III, IV or V) were referred to the appropriate local tumor clinic for diagnosis. If the biopsy was proved to be positive for cancer, treatment was initiated through the regional tumor clinic.

An outgrowth of the project showed cervical scrapes were superior to vaginal aspirations in finding cervical cancer. Drs. Samuel A. Gunn and W. A. D. Anderson, Co-Directors of the project's Central Cytology Laboratory, University of Miami, made a comparison of vaginal aspirations versus cervical scrapes from the first 89 women with positive tissue diagnosis of carcinoma of the cervix. Dr. Gunn reported that no vaginal aspirations were positive when the cervical scrapings were negative. He pointed out that of the 63 cases of carcinoma in situ confirmed, the vaginal aspiration picked up 21; of the 14 cases of invasive carcinomas, the vaginal aspiration picked up seven.

This Cervical Cytology Program was well received in the communities in which it operated. County medical societies, pathologists and tumor clinic personnel were most cooperative and helpful in planning with state and district welfare units and health department personnel in the implementation of the program. This experience has been of value in developing community capability to organize and operate a community health program.

Numerous inquiries about this program from other states prompted the production of a "pic-tape" which documented the steps involved in the planning and implementation of a cervical cytology program in a Florida county. The "pic-tape," a 35mm filmstrip with narration on tape, is available on loan, from the Division of Chronic Diseases, Florida State Board of Health.

The project results indicate an urgent need for continuing cytology programs in Florida to find cancer of the cervix in low socioeconomic groups in the in situ or early invasive stages. At this point the lesion is limited, and the chances of cure are excellent, thus leading to a high rate of salvage of women in this population at a time of greatest value to the community from a parental and economic standpoint. In 1962, 14,000 women died from cancer of the uterus in the United States; 493 of these were Florida women.

Sustained and lasting interest has been sparked by the program in many of the counties. Several county health departments with cooperation of their medical societies, local pathologists, and other groups, have set up cervical cytology as a regular service for the medically indigent.

In recent years the death rate for cervical cancer has been cut, but could be reduced much more by the physicians' continued emphasis on the importance of a Pap smear taken routinely on all women.

James E. Fulghum, M.D.
Simon D. Doff, M.D.
Florida State Board of Health
Jacksonville

Medicine and the Care of the Mentally Ill

The ever increasing problem of the care of the mentally ill has in the past few years resulted in an upsurge of national interest and activity in what is considered America's most pressing and complex health problem. The magnitude and seriousness of the problem led to the passage of the Mental Health Study Act of 1955 which directed the Joint Commission on Mental Illness and Health, whose members were to be selected by the National Institute of Mental Health, to analyze and evaluate the needs and resources of the mentally ill and to make recommendations for a national program.

The Joint Commission, consisting of 45 members with Kenneth E. Appel, M.D., former president of the American Psychiatric Association, as president, presented its final report on Dec. 31, 1960. This report made numerous recommendations for a National Mental Health Program and had the following to say as the enormity of the problem, "The outstanding characteristics of mental health as a public health problem are its staggering size, the present limitations in our methods of treatment, and the peculiar nature of mental illness that differentiates its victims from those with other diseases or disabilities."

Every physician, every day, sees patients with mental illness for whom the necessary treatment is unavailable. There are not enough facilities or personnel to render the necessary services. As physicians, we do not need figures to know that a staggering problem exists, and yet some figures may be of importance in comprehending the problem.

On the number of mentally ill, it is estimated that about 17,000,000 people in the United States suffer from some form of psychological disturbance or mental illness. Nearly 50 per cent of the close to two million hospital beds in this country are occupied by mental patients. As to the cost of mental illness, it is estimated that the direct cost is one billion dollars a year and the indirect costs about three billion dollars a year. With these figures in mind, it should be noted that there are about 300,000 physicians in the United States and of these about 15,000 are psychiatrists.

In dealing with the problem advances in two areas have helped to some extent. The first has been the development and use of new drugs in the treatment of all categories of mental illness. The second has been the increase in modern facilities. In June 1963, the United States Senate passed a bill for the expenditure of 847 million dollars over 10 years to help construct and staff community mental health centers and to provide grants for research and facilities in the mental retardation field.

The increase in facilities and the use of drugs do not provide the answer to the problem because in the treatment of mental illness the most important factor is people, trained people. Since the nation's medical schools could never train enough psychiatrists, it should be the responsibility of the medical profession to create a new helping profession in mental health.

On this matter, the following is taken from The Final Report of the Joint Commission: "Dr. Albee entertains the idea, as others have originated and discussed it, of creating a new helping profession in mental health. The training of a fully qualified psychiatrist requires 13 to 14 years beyond high school. The proposal is to create a new person carefully trained in psychotherapy but without the lengthy basic medical, general clinical and advanced specialty training—a person to be trained in a maximum of four college years. Presumably, such a person would work under adequate supervision and in a publicly accepted health agency."

With a helping profession at his side, the role of the psychiatrist could change from one of a harrassed practitioner to that of an educator, researcher, consultant and therapist who would use all the other forms of therapy available besides psychotherapy in the more difficult cases. Medicine, in creating and regulating a helping profession of psychotherapy, will provide better care for the mentally ill and thus come closer to its goal of the best possible total care of the patient.

Louis Alper, M.D.
Miami

FLORIDA MEDICAL ASSOCIATION ORGANIZED 1874

Maternal Death in Florida

Maternal deaths occurring in Florida during 1962 were studied by the Committee on Maternal Health in its second annual Maternal Mortality Survey. A total of 52 deaths was reported. Two deaths under the care of osteopaths and one under the care of a doctor of medicine, not a member of the Florida Medical Association, were not available for inquiry. Thus, 49 deaths were studied, and 48 were classified. One death, which took place in a remote area, could not be classified because of insufficient data.

Every physician who received the Committee's questionnaire responded willingly, usually promptly, and often in greater detail than was requested. The excellent physician cooperation was also reflected in the high autopsy rate—35 autopsies out of 49 deaths.

The terminology of mortality surveys should be considered briefly. In order to compare its results with those of other states, Florida uses the Maternal Death Rate (the death of any woman dying of any cause whatsoever while pregnant or within 90 days of the termination of pregnancy). The Maternal Death Rate is less informative and always slightly higher than the Obstetric Death Rate (the number of deaths due to direct obstetric causes). All rates are expressed in terms of maternal deaths per 10,000 live births.

Statistical Study

Florida — 1962

Total live births — 115,248
Total maternal deaths — 52
Maternal death rate — 4.7
Maternal death rate — white — 2.7
Maternal death rate — nonwhite — 10.1

A comparison with the Maternal Rates of other states, regions and the nation is of interest.

Maternal Death Rates — Elsewhere

United States — 3.0 — 1962, preliminary
South Atlantic States — 5.14 — 1958-1960
Mississippi (highest) — 8.60 — 1958-1960
Minnesota (lowest) — 1.46 — 1958-1960

Florida's rate is thus above the national average, but below the average of the South Atlantic States. For the past decade, the safest region for childbearing has been the New England States, where mortality rates consistently have been held the lowest. As anticipated, the rates in various states vary directly with the ratio of physicians to population, and with the ratio of white to nonwhite patients. For the past several years, childbirth has been four to five times more hazardous in Florida for nonwhite than for white patients.

Florida has made remarkable progress in lowering its mortality rates in the past two decades. The white rate has dropped from 49.6 in 1940 to 2.7 in 1963, a reduction of 95 per cent. In the same period the nonwhite rate has dropped 91 per cent, from 98.1 in 1940 to 10.1 in 1963. These are encouraging figures, but the room for improvement in Florida's mortality is obvious.

Classification by Diagnosis

The 48 maternal deaths were studied, and were classified, according to the AMA National Classification System, as follows:

I. Direct Obstetric Causes
- A. Hemorrhage — 15
- B. Toxemia — 5
- C. Infection — 8
- D. Vascular accidents — 13
 - Amniotic embolism — 6
 - Thrombotic embolism — 5
 - Air embolism — 1
 - Cerebrovascular accident — 1
- E. Anesthesia — 3
 - All cardiac arrests

II. Indirect Obstetric Causes
- D. Urinary tract disease — 1
- H. Other — 2
 - Sickle cell crisis — 1
 - Appendicitis with rupture — 1

III. Nonrelated Causes
- F. Accidental
 - Rupture of rectovaginal septum by self-administered enema

No matter how much care and deliberation are used by any classifying body, no classification of death is as clearcut as finally reported. Eastman and others have pointed out that causes of maternal deaths are often dual and concurrent in nature. This was particularly true of the 15 deaths attributed here to hemorrhage. In half of these patients, the basic disease process was toxemia, although it was hemorrhage due to placental disruption which killed the patient. Likewise, infection was the underlying cause of thrombi in five deaths from pulmonary embolism. It should be noted that this Committee rarely accepts a diagnosis of embolism of any kind without verification by autopsy.

The rise in the ratio of embolic deaths to other major causes is significant. It is quite conceivable that, as deaths due to hemorrhage, toxemia and infection decrease, embolism may emerge as a fourth major cause of death. This has already happened in gynecologic surgery, where embolic and anesthetic deaths have replaced hemorrhage and infection in order of frequency.

The three anesthetic deaths presented the usual problems of classification. All were typical clinical pictures of cardiovascular collapse. One took place during induction and two during emergence from anesthesia. There was no associated hemorrhage. Closed chest massage was employed in two patients and the thorax was opened in the third. Autopsy, performed on all three, showed no other cause of death.

The three indirect causes of death followed predictable patterns. In spite of recent increased awareness of appendicitis in pregnancy, the disease remains difficult to diagnose and treat. It appears almost yearly in the mortality studies of each state.

Of four patients dying from ectopic pregnancy, three were dead on arrival in the emergency room, all three not having sought or having refused medical advice. The fourth patient is described in a following paragraph.

Several unusual causes of death deserve mention. Two patients with early clinical preeclampsia were admitted to the hospital solely because of acute, severe pain over the liver. Both died promptly, one of a ruptured liver and the other of cerebrovascular hemorrhage. At autopsy, both showed enormous enlargement of the liver due to toxemia,

the pain having been caused by stretching of Glisson's capsule. These patients remind us, all too well, that one of the most often overlooked symptoms of toxemia is hepatic pain.

One patient with tubal pregnancy progressed, with pain, to 35 weeks gestation and died after attempted removal of the placenta from the intraligamentous portion of the broad ligament. The ovisac, containing a macerated fetus, was found to be covered still with thin, attenuated strands of tubal muscularis.

Eight days after normal delivery, while attempting to take an enema, a primipara ruptured the lower third of the rectovaginal septum. She died of massive hemorrhage in spite of early and adequate attempts at blood replacement.

A multipara, after seven years of secondary infertility due to endometriosis, died during term delivery of hemorrhage from torn endometrial implants between the uterus, pelvic wall and intestines. The diagnosis was established at autopsy. A report of this case, now being prepared for publication, will be the third in the world literature.

Factors of Preventability and Responsibility

Factors of Preventability — 48 Deaths
- None — 27
- Patient — 10
- Physician — 9
- Patient and physician — 2

Factors of Responsibility — 48 Deaths
- None — 27
- Patient — 11
- Physician — 7
- Patient and physician — 2
- Hospital — 1

Assessment of factors of preventability and responsibility, always done in a retrospective and necessarily ideal sense, remains a difficult and often thankless task. Yet, without such classification, a survey has little use or meaning. In the vast majority of deaths, the physician can be reassured by this evaluation that his management was proper and adequate. In the deaths in which professional factors were involved, the Committee has no desire or authority to censure, but rather to help the individual physician, and indeed all of us, to learn by experience.

It is regrettable that the Committee must use only this general essay form of reporting its studies. At present, without adequate protective legislation, the responding physician cannot be individually informed, nor can he profit adequately by the findings of the Committee and its consultants.

Recommendations

A Maternal Mortality Survey enters so many areas of study that a number of recommendations present themselves each year. No purpose would be served, however, by such wholesale approach. Rather the Committee would prefer to offer each year the few most pressing recommendations.

As long as hemorrhage remains the chief cause of maternal deaths, as it has the past two years, the major effort must be aimed against it. In most of the deaths studied, whole blood was given, but usually too little and too late. There was seldom a delay in ordering blood, but almost always a delay in obtaining it, when it had to come from another hospital. It was the delay in transportation which was so commonly fatal. Too many hospitals of medium to large size, in urban areas, were found to have no blood bank or reserve of their own. These hospitals justify the absence of a blood bank by pointing out that they successfully carry a large schedule of elective surgery each day and have adequate blood.

Obstetric blood replacement is a totally different problem. Obstetric hemorrhage is often unpredictable, abrupt, and massive. Our members and consultants believe that no hospital offers complete obstetric service unless whole blood is immediately available within the hospital itself. The establishment of whole blood reserves within each hospital whenever and wherever possible is the Committee's first recommendation.

The second recommendation is for the continued effort for passage of the Bill for Protection of Scientific Studies in the 1965 state legislature. Although this law has been adopted by a number of other states, it did not go beyond the Association's Legislative Committee in 1963. Without such legislation, the transactions of every medical investigative body in the state are freely admissible as court evidence. This law is essential to a good Maternal Mortality Survey, but it is much more vital for the protection of committees at state, county and hospital levels, such as Boards of Censors, Grievance Committees and Medical Audit Committees. The passage of this bill in 1965 should be urged by every member of the Florida Medical Association.

The Committee on Maternal Health expresses its sincere gratitude to the physicians responding this year for their unfailing cooperation. Grateful acknowledgment is made by the Chairman to the Committee members, Drs. Joseph W. Douglas, James R. Sory, Richard F. Stover and Stephen L. Watson, Jr., and to its consultants, Dr. Lorenzo L. Parks and Harry Prystowsky, for their constant and untiring efforts.

James M. Ingram Jr., M.D., Chairman
Committee on Maternal Health
Tampa

Summary of Board of Governors Meeting Held January 12, 1964

FMA Budget 1964.—Approved the financial statement for 1963 and adopted the budget for 1964 of $263,000 plus $25,000 for reserve and land acquisition, based upon an anticipated income of $285,000. In 1963 the Association's income was $286,571, expenses $247,804 for a gross gain of $38,767. Total assets of the Association as of December 31, 1963, were $410,923.

1964 AMA Clinical Session.—Considered arrangements to host the AMA 1964 Clinical Session in Miami Beach, November 30 to December 3, 1964.

Council and Committee Reports.—Approved a deadline date of March 1, 1964, for committee reports and March 15, 1964, for Council reports, and set the date of April 4-5 for the next meeting of the Board of Governors.

Medical Protective Company.—Rejected the application of Medical Protective Company as a technical exhibitor at the Annual Meeting and recommended to The Journal that it not accept advertising from this company beyond their present contract.

FLAMPAC.—Approved the FMA Executive Office assisting an organization on a reimbursed basis for educational purposes and any other way possible which would not jeopardize its tax-exempt status.

Annual Meeting.—Voted to recommend to the House of Delegates that the 1967 Annual Meeting be held in Hollywood and that the Association alternate between the Diplomat and the Americana through 1970, subject to satisfactory arrangements being made.

Legislation.—Reviewed and approved a report of the

Council on Legislation and Public Agencies concerning both national and state legislation, which, among other recommendations, urged that the county medical societies push "Operation Hometown" now with special emphasis on information to lay groups, encouraging them to write their Congressmen and Senators, but that we do not urge doctors to write their delegation at this time.

Medicine and Religion.—Approved a report of the Ad Hoc Committee on Medicine and Religion recommending that this be made a standing committee of the Association. This will appear in the Board's recommendations to the House of Delegates.

Automotive Crash Injury Research Program.—Reaffirmed its approval of the Cornell Automotive Crash Injury Research Program to be conducted in Florida and agreed to cooperate in this project.

Rural Health Conference.—Extended an invitation to the American Medical Association to hold the Rural Health Conference in Miami Beach in 1965.

Investment Plan.—Approved the Amended Declaration of Plan, Rules and Regulations, Custodial Agreement and Custodial Agent Authorization Form for the Florida Medical Association Investment Plan.

Key Contact Physicians.—Reappointed the Key Contact Physicians for 1964 for each member of the Florida Congressional delegation.

Council and Committee Handbook. — Approved the text of a Council and Committee Handbook, entitled "What Every Chairman Should Know," and authorized its publication.

Executive Director.—Approved a resolution of appreciation to W. Harold Parham, Executive Director, and agreed to a five-year contract for his services.

AMA Membership. — The Executive Committee reviewed the fact that there are over 12,000 retired physicians in America, approximately 1,100 of them in Florida. The Executive Committee requests that all county medical societies contact these retired physicians and try to bring them into the organization in some associate capacity.

Sixth Annual Conference Of County Medical Society Presidents and Secretaries

A new attendance record of 130 persons was reached at the Sixth Annual Conference of County Medical Society Presidents and Secretaries, held for the first time in Orlando on January 25 and 26, 1964. The five previous sessions had been held in Jacksonville. Of the total attendance, there were 95 physicians from 28 societies representing 95 per cent of the membership of the Florida Medical Association, the sponsoring organization.

In opening the two day meeting, held at the Robert Meyer Motor Inn, President Warren W. Quillian reminded the county society officers of the opportunity afforded by the conference to promote closer liaison between the state association and the local societies. Dr. Quillian remarked that while the current status of the Association is good, there are certain goals and objectives which must be met with a united front if the fight for medicine as a private enterprise is to be successful. He urged the county medical societies to increase the active participation and interest of their members and suggested three specific areas for attention: (1) greater utilization of the talents of the large number of retired physicians in the state; (2) more intensive promotion of American Medical Association membership, and (3) increased use of the Woman's Auxiliary.

Following his opening remarks, Dr. Quillian introduced the guest speaker, Dr. Ernest B. Howard, Assistant Executive Vice President of the American Medical Association. Dr. Howard gave a synopsis of progressive changes in American medicine as interpreted by the Board of Trustees of the national organization and emphasized their relationship to the practice of medicine. He concluded by outlining proposals for specific action to combat the various difficult problems facing medicine.

The next presentation was a panel discussion concerning indigent care and medical services moderated by Dr. Charles R. Sias of Orlando, chairman of the Association's Council on Medical Services. Panelists included Dr. Nelson Zivitz of Miami Beach, chairman of the Committee on Indigent Care, who described the state's current programs in this field; Dr. H. Phillip Hampton of Tampa, chairman of the Council on Legislation and Public Agencies, who discussed improvements needed in the programs; Dr. Irving E. Hall Jr., of Bradenton, chairman of the Committee on Child Health, whose subject was child and school health; Dr. Zack Russ Jr., of Tampa, chairman of the Committee on Mental Health, who described current activities in that field, and Dr. Wilson T. Sowder of Jacksonville, State Health Officer, who described programs of interest in the public health area.

A Medical Economics panel covered the subjects of Blue Shield, utilization and review committees, workman's compensation and medicare. Speakers included Dr. W. Dean Steward of Orlando, president of Blue Shield of Florida; Dr. David J. Lehman Jr. of Hollywood, member of the Committee on Commercial Health Insurance, and Dr. Henry J. Babers Jr. of Gainesville, chairman of the Committee on Fee Schedules.

A Legislative Program panel consisted of Dr. Joseph C. Von Thron of Cocoa Beach, member of the AMA Speaker's Bureau, and Dr. George S. Palmer of Tallahassee, chairman of the Committee on State Legislation. Dr. Von Thron described the national legislative program and "Operation Hometown." Dr. Palmer discussed the Association's state legislative program. Following the presentations, Mr. Alvin D. James, an Assistant Executive Director of the Association, and Mr. Richard M. Nelson, Field Representative of the American Medical Association, assisted in answering questions.

The final subject on the first day's program was the various membership programs sponsored by the Association. Dr. Robert E. Zellner of Orlando, immediate Past President, described the various insurance programs available to the membership, while Dr. Floyd K. Hurt of Jacksonville, Secretary-Treasurer, discussed the Association's Investment Plan.

Dr. Samuel M. Day of Jacksonville, President-Elect of the Association, presided over the Sunday morning session. Individual round table discussions for the county society officers were held on the following subjects: indigent care programs, medical economics, legislation, medical services, and management and administration. Conference participants remained at the same tables while moderators for each subject changed at regular intervals. Respective moderators for the various subjects were Dr. Hampton and Dr. Simon D. Doff of Jacksonville, Director of the Bureau of Special Health Services, Florida State Board of Health; Dr. Babers and Mr. N. G. Johnson of Jacksonville, Medicare Coordinator, Blue Shield of Florida; Dr. Palmer and Mr. James; Dr. Sias and Mr. Eugene L. Nixon, an Assistant Executive Director of the Association; and Dr. Jere W. Annis of Lakeland, a past president, and Mr. W. Harold Parham, Executive Director.

Following stimulating discussions of a broad range of state and local programs, the conference was adjourned.



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News

A postgraduate symposium in "Pediatrics—The Sick Child in General Practice" is being presented April 9-11 in the auditorium of Mound Park Hospital and the clinics of the American Legion Hospital for Crippled Children in St. Petersburg. For the course, 18 credit hours in Category I will be allowed by the American Academy of General Practice.

The need for an historical and philosophical collection of books and papers of interest to medicine and the history of medicine in Florida and the Southeast exists within the library of the J. Hillis Miller Health Center of the University of Florida at Gainesville. Persons desiring to offer donations to the collection should contact Dr. George T. Harrell, Dean of the College of Medicine, or Dr. D. R. Shanklin, Assistant Professor of Pathology and Pediatrics of the College. The lecture series on the history and philosophy of medicine sponsored by the College of Medicine is presently in its second year.

A Postgraduate Seminar in Arthritis and Related Diseases and Care and Prevention of Musculoskeletal Injuries will be held March 13-14 at the Hotel George Washington in Jacksonville. Sessions scheduled for the first day are limited to physicians. The following day when musculoskeletal injuries will be discussed, the program should also appeal to coaches, trainers, athletic directors, physical therapists and nurses.

A one week course in "Principles of Rehabilitation of the Physically Handicapped" has been scheduled for March 2-6 at the Rehabilitation Center in Miami. It is sponsored by the University of Miami School of Medicine and the Rehabilitation Center for Crippled Children and Adults.

A one day symposium on Gynecologic Endocrinology and the Stein-Leventhal syndrome will be held in Augusta, Ga., on Thursday, March 19. It is sponsored by the local county medical society and the Medical College of Georgia.

Drs. Ralph E. Balch and I. Kimbell Hicks of Melbourne and Dr. William J. Creel of Eau Gallie were honored at a recent testimonial dinner held at the Eau Gallie Yacht Club by the medi-

cal staff of Brevard Hospital. Dr. Balch, dean of the physicians in Brevard County, was the special guest of honor at the dinner. The Daily Times in an editorial comment published a few days following the affair stated that "the entire community joins in paying respect to this 90 year old physician whose love of life and public service have kept him both interested and interesting through a vastly changing time in America."

New Members

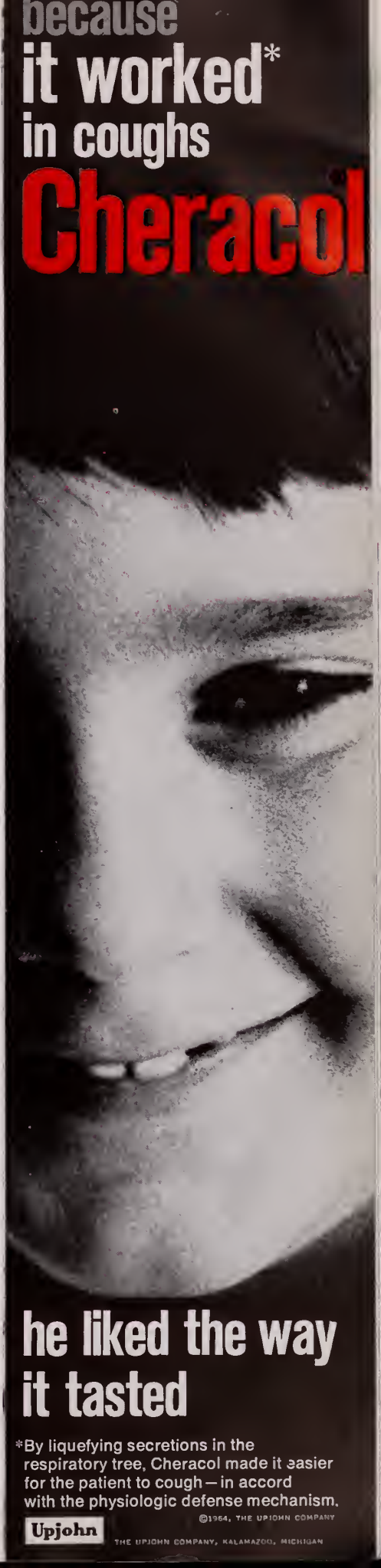
The following doctors have joined the State Association through their respective county medical Societies.

Active

Brendle, Luther A., Clearwater
Camberg, Richard L., Eau Gallie
Crage, Paul F., Stuart
Daniels, Richard E., Pensacola
Dukes, Herbert T., Pensacola
Gomez, Henry R., New Port Richey
Gregory, Ben T., Pensacola
Hill, Hugh M., Gainesville
King, Jerald P., Pensacola
Leeds, Paul, Rockledge
Mason, Robert H., Tampa
Minovitch, Eva S., Cocoa
Mitchell, Calvin H., Tampa
Moorhead, Frank A., Tampa
Norenberg, Richard G., St. Petersburg
Popp, Edward M., Tampa
Rieman, Robert D., Fort Pierce
Schilt, Clarence H., Fort Myers
Smitherman, F. Byron, Clearwater
Williams, Mary H. M., Avon Park
Wilson, Charles A., Pensacola

Associate

Adkins, William R., West Palm Beach
Alfonso, Alvaro, West Palm Beach
Arnas, George M., Lantana
Becker, Charles O., Venice
Bennett, Louis D., Hollywood
Bishop, Richard C., Fort Lauderdale
Bond, Auraldo G., Pompano Beach
Bowman, James P. II, Lakeland
Buckner, Charles M. Jr., Lakeland
Bullard, Foster L. Jr., Tallahassee
Byron, Richard C., St. Petersburg
Campbell, Arthur S., Miami Springs
Cason, James F., Winter Haven
Chapman, William L., Sarasota
Cintron-Villaronga, Guillermo, Miami
Cole, David O., Tallahassee
Cole, Sanford H., Miami
Copenhaver, Richard M., Gainesville
Crisler, Morris Mc. Jr., Clearwater
Crist, Donald R., Gainesville
Daly, William M., Lakeland
Das Neves, Fernando, Miami
Doucette, Jack W., St. Petersburg
Duperret, Donald L., West Palm Beach
Feuerman, Martin N., Hollywod
Giordano, David A., Sarasota
Gustafson, William L. Jr., Miami



Harper, John M., Miami
Hobby, Royce, St. Petersburg
Jones, Richard B., Lakeland
Kirby, W. Leslie, Delray Beach
Knight, Wallace A., Boca Raton
Kromer, Robert A., Hollywood
Letchworth, George W., Sarasota
Liebling, Martin E., Miami
McKenzie, Doris, Miami
Major, James C., Coral Gables
Mann, Joel B., Miami
Mason, John F. Jr., Gainesville
Nunnally, Lester C., Orlando
Page, William L., Sarasota
Palmer, Robert D., Miami
Panaro, Robert J., Fort Lauderdale
Piano, Arthur G. F., Palm Harbor
Porton, Frederic C., Miami
Powell, Louis F. Jr., Clearwater
Pruitt, John C., St. Petersburg
Reeder, Robert L., Fort Lauderdale
Ring, Henry G., Miami
Rubin, Melvin L., Gainesville
Rush, Joseph C., St. Petersburg
Sanford, Howard S., Miami
Schultz, Gerald T., Fort Lauderdale
Sellati, Jack J., Winter Garden
Shanklin, Douglas R., Gainesville
Shea, Peter C., Kendall
Simpson, John T. Jr., Tallahassee
Wallace, William E., Sarasota
Watson, Allen S. Jr., Fort Lauderdale
Welty, Paul B. Jr., St. Petersburg
Wiener, Stanley M., Sarasota
Williams, Clyde M. Jr., Gainesville
Williams, Robert E., Lakeland
Zimmerman, Aaron H., Miami

Meetings

March

Sixth Annual Medical Forum, Lee-Hendry County Medical Society and Lee County Chamber of Commerce, March 4-5, Exhibition Hall, Fort Myers.

Seminar in Neurology, March 5-7, University of Florida College of Medicine, Gainesville.

Cancer Seminar, Pinellas County Unit of American Cancer Society, March 6-7, Fort Harrison Hotel, Clearwater.

Annual Seminar, Watson Clinic, March 7, Lakeland

Postgraduate Seminar in Arthritis and Related Diseases, and Care and Prevention of Musculoskeletal Injuries, Florida Chapter of the Arthritis and Rheumatism Foundation, March 13-14, Hotel George Washington, Jacksonville.

"Evolving Concepts in Pulmonary Diseases," Department of Radiology, University of Miami School of Medicine and Jackson Memorial Hospital, March 18-21, Hotel Fontainebleau, Miami Beach.

Southeastern Surgical Congress, March 21-28, S. S. Hanseatic sailing from Port Everglades, Fort Lauderdale.

"Principles in the Rehabilitation of the Physically Handicapped," Crippled Children's Society of Dade County, March 2-6, Rehabilitation Center, Miami.

April

"Pediatrics—The Sick Child in General Practice," April 9-11, Auditorium of Mound Park Hospital, St. Petersburg.

May

Ninetieth Annual Meeting, Florida Medical Association, May 7-10, Diplomat Hotel, Hollywood-by-the-Sea.

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Bibliography: 1. Williams, R. H.: Textbook of Endocrinology, Ed. 3, Saunders, Philadelphia, 1962, p. 610. 2. Gordon, E. S.: Metabolism 11:819, 1962. 3. Grodsky, G. M. et al.: Metabolism 12:278, 1963. 4. Sadow, H. S.: Metabolism 12:333, 1963. 5. West, K. M. and Tophoj, E.: Metabolism 10:689, 1961. 6. Yalow, R. S. and Berson, S. A.: Diabetes 9:254, 1960. 7. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 8. Weller, C. et al.: Metabolism 11:1134, 1962. 9. Radding, R. S. et al.: Metabolism 11:404, 1962.

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Clinical Comment

Florida Society of Anesthesiologists

The fall meeting of the Florida Society of Anesthesiologists was held in Tampa on Oct. 19, 1963. Presenting the program for the scientific session were Dr. Oral B. Crawford, Springfield, Mo., Dr. Frank Moya, University of Miami School of Medicine, Coral Gables, Thomas H. Crawford Jr., Jacksonville attorney, and Frank M. Arnall II, C.L.U., Jacksonville.

Discussing "Factors Which Affect the Spread of Anesthetic Solutions in Peridural Space," Dr. Crawford reported that there was a wide variety of opinion in the existing textbooks regarding the volumes, dosages and techniques used in epidural blocks. An interesting study was presented indicating the mechanism of these variables. The conclusion was that if such variables as gravity, size of patient, type of drug, and volume of solution are recognized, epidural block will be more predictable.

"Regional Versus General Anesthesia for Obstetrics" was the subject presented by Dr. Moya. He summarized his excellent talk by reiterating that regional anesthesia is the technique of choice in obstetrical anesthesia. In the event this is contraindicated, analgesia with cyclopropane and the use of succynldicholine is preferred. Contraindicated is the use of deep anesthesia with any agent. The talk was reinforced with many slides illustrating the principles involved.

Mr. Crawford and Mr. Arnall discussed "Professional Corporations and Kintner-Type Associations." They detailed the origin, growth, and development of the professional corporation. The application of this concept to the economic phase of the professional man was explained thoroughly. The Professional Service Corporation Act was passed by the Florida legislature in September 1961, thereby permitting physicians to use the mechanics of a corporation in their own economic planning. The two speakers presented means for the application of this law.

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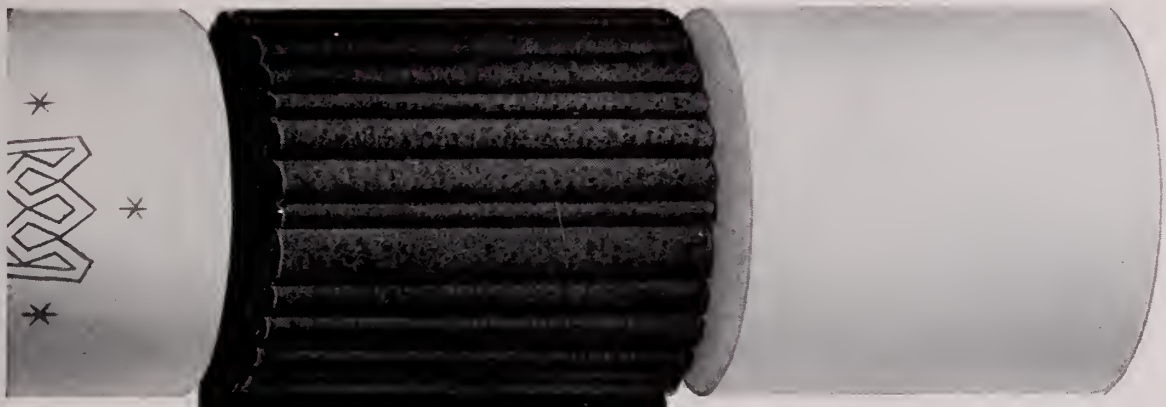
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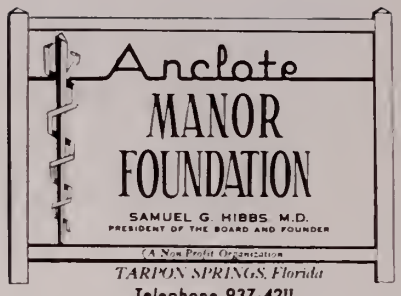
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[1] Simon, F. & Bernstein A.: "The Treatment of Obesity in Patients with Cardiovascular Disease," Angiology, *12*:32-37, Jan. 1961.
[2] Plotz, M.: Modern Management of Obesity, J.A.M.A. *170*:1513-1515 (July 25) 1959.
[3] Bernstein, A. & Simon, F.: "Treatment of Obese Diabetics and Arteriosclerotics," Clin. Med. 907-920, May 1961.

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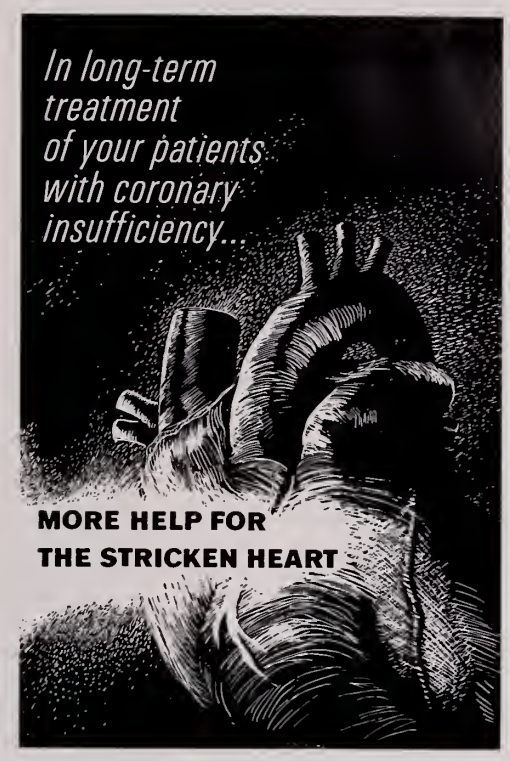
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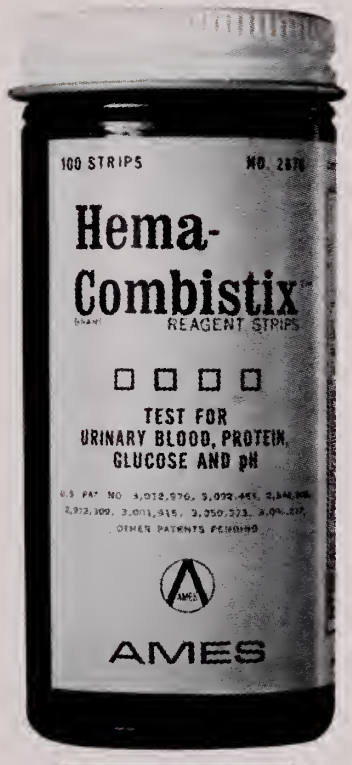
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*Roseman, E.: *Neurology* **11**:912, 1961. 33664

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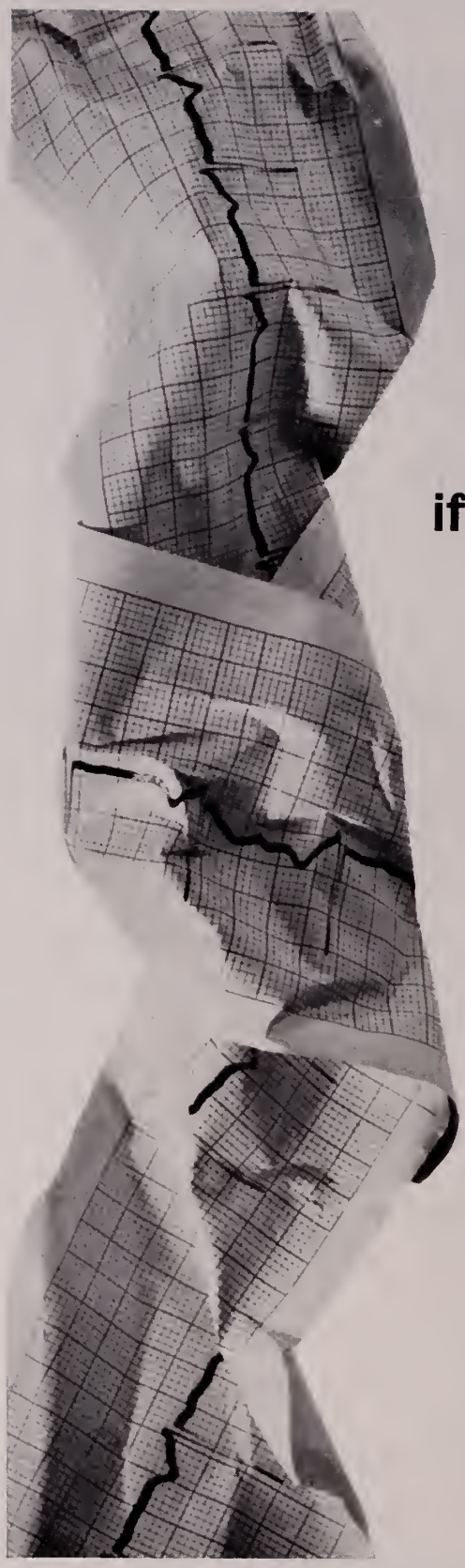
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It happens, even to the best of machines.

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certain undesirable metabolic effects — including s
and water retention, edema, overstimulation of t
appetite, excessive weight gain, mood swings
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advent of ARISTOCORT® Triamcinolone, many
these arthritics became "steroid-treatable." The r
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of inflammation and pain, but it did so *without* t
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PATIENT NO. 1	PATIENT NO. 2
may require higher dosage in the morning.	may require extra sedation at night.

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It's Easy to Adjust the Dosage with the Tetrasule Family

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PENTAERYTHRITOL TETRANITRATE 30 mg.

Dosage: One timesule upon arising, and one 12 hours later. May be increased to 2 Timesules A.M. and/or P.M., as required.

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Dosage: For the patient who requires approximately 27.6 mg. each 4 hours: One Timesule upon arising, and one 12 hours later.

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a working analgesic for the active arthritic



ARTHRALGEN®

Each tablet contains:

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Ascorbic acid (Vitamin C)	25 mg.

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ARTHRALGEN®-PR

Each tablet contains:

Salicylamide	250 mg.
Acetaminophen	250 mg.
Ascorbic acid (Vitamin C)	25 mg.
Prednisone	1 mg.

The basic Arthralgen formulation plus prednisone is indicated for patients who require steroids. Prednisone has three advantages over cortisone, hydrocortisone, and ACTH. They are: (1) lack of sodium retention, (2) absence of increased potassium excretion, and (3) the unlikelihood of steroid-induced hypertension.*

Robins

BRIEF SUMMARY

Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

DOSAGE: One or two tablets four times a day. After remission of symptoms, dosage should be reduced to the minimum maintenance level.

SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticoidism dictate reduction of dosage of Arthralgen-PR.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomylitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

*Cohen, et al: J.A.M.A., 165:225, 1957.

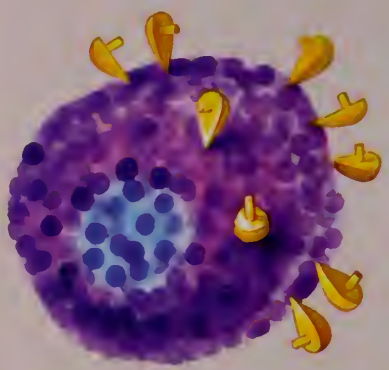
A. H. ROBINS CO., INC., RICHMOND, VIRGINIA

In theory, allergy works like this...

It is generally accepted that a complex antigen-antibody reaction underlies allergy. The reaction may be visualized in this simplified graphic form:



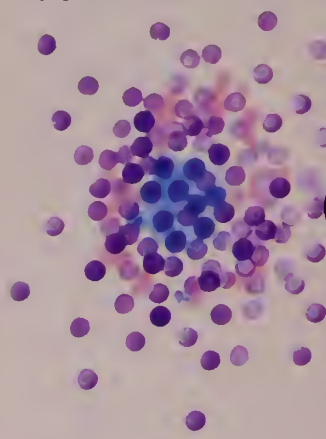
At first exposure to antigens (green) specific antibodies (yellow) are formed chiefly by plasma cells.



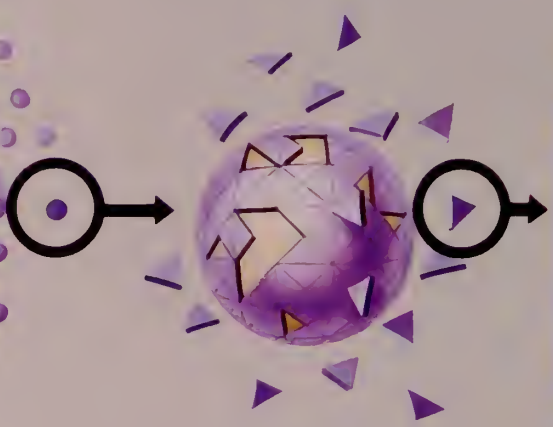
Circulating antibodies in the blood stream may become attached to mast cells in the tissues.



If the same *antigen* again enters the body and reacts with *antibodies* attached to cell walls, disturbances occur. The cell disrupts...



...depositing granules containing bound histamine or histamine-like substance in intercellular spaces.



Calcium ions and enzymes act on the granules breaking the binding and releasing histamine or histamine-like substance.



Theoretically, this liberated histamine (purple) acts at *receptor sites* in target tissues resulting in allergic manifestations.



Antihistamine (orange) is believed to compete with histamine at the receptor sites in target tissues – thus counteracting allergic effects.

In allergy, this antihistamine works with no more sedation than placebo*

The therapeutic response to Dimetane (brompheniramine maleate) is eloquent proof that a *potent* antihistamine does not have to be a sedative, too. You may expect unsurpassed relief of symptoms promptly in most types of allergy because Dimetane (brompheniramine maleate) *works* with a very low incidence of side effects. Indeed, as shown in a double-blind crossover study, with no greater incidence of sedation than placebo.*

*Schiller, I. W. and Lowell, F. C.: New England J. Med. *261*:478, 1959.

CONTINUOUS ACTION UP TO 10-12 HOURS

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(brompheniramine maleate, 8mg.&12mg.)

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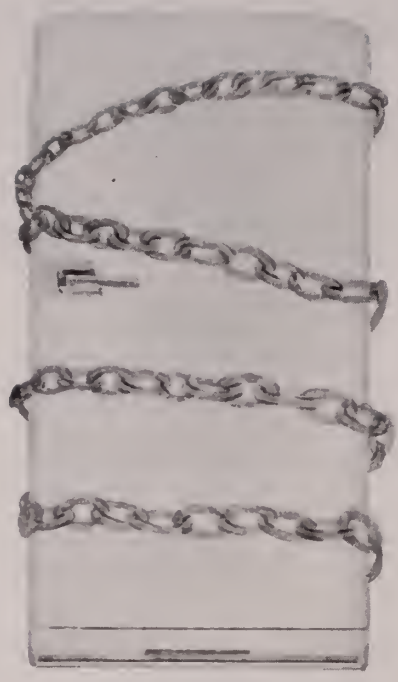
Side Effects: Hypersensitivity reactions, including skin rashes, urticaria, hypotension, and thrombocytopenia, have been reported rarely. Occasional transitory drowsiness, lassitude, nausea, or giddiness may be encountered. Dryness of the mouth and mydriasis have been reported infrequently.

Precautions: Until response is determined, patient should be cautioned against engaging in mechanical operations requiring alertness.

Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

ALSO AVAILABLE: New lower strength Dimetane *8 mg.* Extentabs (brompheniramine maleate 8 mg.); conventional tablets (4 mg.); Elixir (2 mg./5 cc.); Injectable (10 mg./cc. ampuls, and 100 mg./cc. in 2 cc. vials).

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METHAMPHETAMINE HYDROCHLORIDE

is an easier way to help control food craving & keep the reducer happy

With "hunger pains" abolished, the patient can shrug off the chains of psychogenic craving that bind him to his habit of overeating and cooperate cheerfully with the prescribed diet.

In obesity, "...our drug of choice has been methedrine (methamphetamine hydrochloride)...because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent." Douglas, H. S.: West. J. Surg. **59**:238 (May) 1951.

Description: Each scored tablet contains 5 mg. 'Methedrine' brand Methamphetamine Hydrochloride.

Dosage: 2.5 mg. (½ tablet) 3 times daily. May be increased gradually according to response; more than 10 mg. daily rarely is needed. The last dose of the day should not be taken later than 6 hours before bedtime.

Side effects: Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Contraindications and precautions: Should not be used in patients with myocardial degeneration, coronary disease, marked hypertension, hyperthyroidism, insomnia or a sensitivity to ephedrine-like drugs. Moderate hypertension in the obese is not necessarily a contraindication since it may be relieved as the overweight is reduced.

Supplied: Tablets 5 mg., scored, in bottles of 100 and 1000.

Complete literature available on request from Professional Services Dept. PML.

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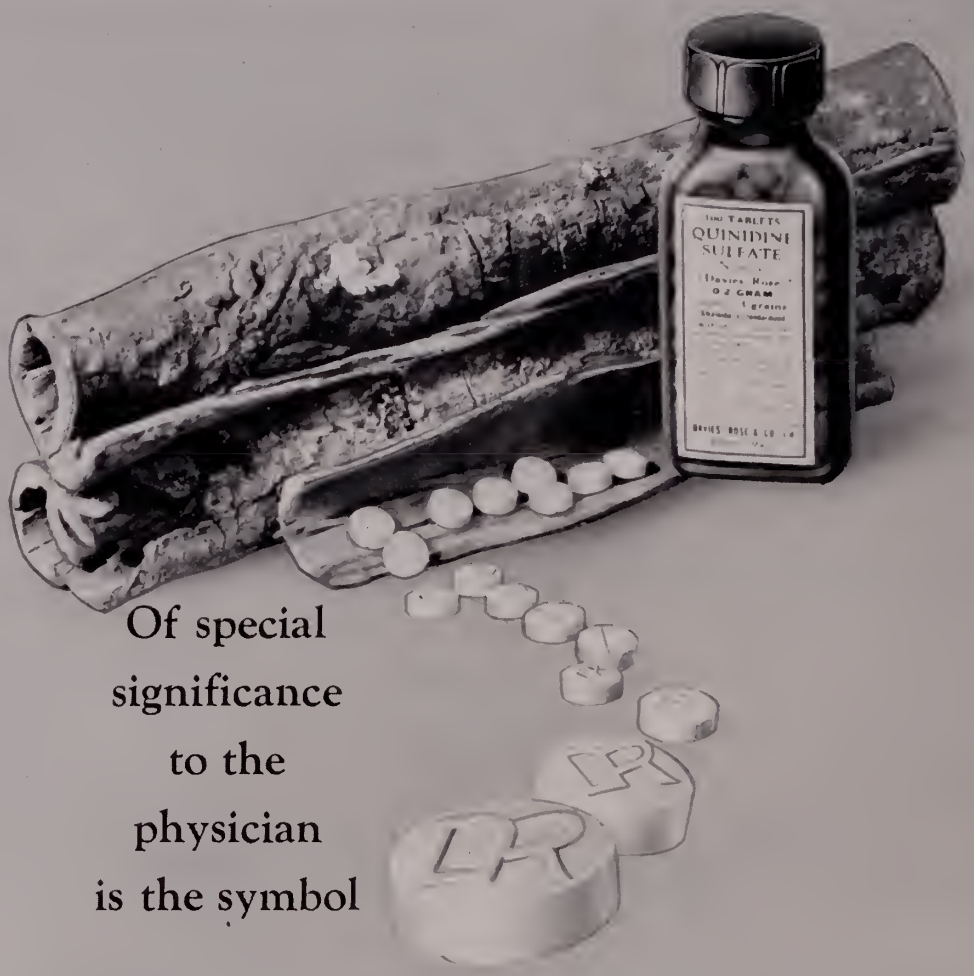
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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).



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When he sees it engraved on a Tablet of Quinidine Sulfate he has the assurance that the Quinidine Sulfate is produced from Cinchona Bark, is alkaloidally standardized, and therefore of unvarying activity and quality.

When the physician writes "DR" (Davies, Rose) on his prescriptions for Tablets Quinidine Sulfate he is assured that this "quality" tablet is dispensed to his patient.

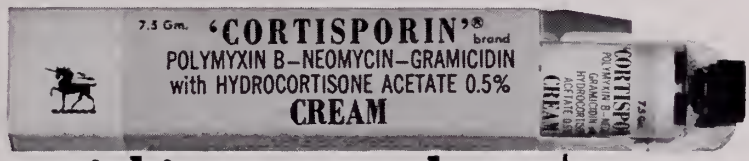
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0.2 Gram (or 3 grains)
Davies, Rose

Clinical samples sent to physicians upon their request

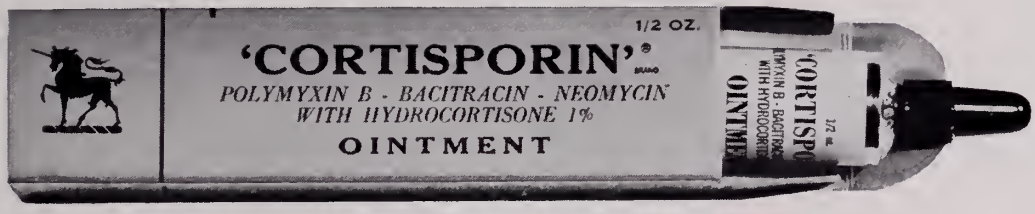
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CHOOSE THE PRODUCT TO FIT THE NEED



a new vanishing cream base



a special low melting point base

anti-inflammatory
bactericidal
antipruritic
rarely sensitizing

CREAM—*Ingredients:* Each gram contains 'Aerosporin'® brand Polymyxin B* Sulfate 10,000 Units; Neomycin Sulfate (equivalent to 3.5 mg. Neomycin Base) 5.0 mg.; Gramicidin 0.25 mg.; Hydrocortisone Acetate 5.0 mg. (0.5%).

In a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, distilled water, and 0.25% methylparaben as preservative.

Available: In tubes of 7.5 Grams.

OINTMENT—*Ingredients:* Each gram contains 'Aerosporin'® brand Polymyxin B* Sulfate 5,000 Units; Zinc Bacitracin 500 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base); Hydrocortisone 10 mg. (1%).

In a special white petrolatum base.

Available: In tubes of ½ oz. and ⅛ oz.

*U.S. Patent Nos. 2,565,057–2,695,261

Indications: Wherever inflammation or infection occurs and is accessible for topical therapy.

Contraindications: These drugs are contraindicated in tuberculous, fungal or viral lesions (herpes simplex, vaccinia and varicella).

Caution: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



The discharged mental patient . . . and Thorazine®

brand of chlorpromazine

"The average practitioner is quite capable of handling the vast majority of ex-institutionalized patients by regulation of medication, reassurance, manipulation of the environment where necessary, and . . . other technics." Kline, N.S.: Postgrad. Med. 27:620 (May) 1960.

The family physician must often assume responsibility for the discharged mental patient. Thorazine (chlorpromazine, SK&F) can be a valuable adjunct to the continuing care of this patient, because it helps prevent relapses by insulating him from the impact of stressful experiences. For successful rehabilitation and prevention of rehospitalization, however, the former mental patient—and often his family—also needs the guidance and counsel of his physician.

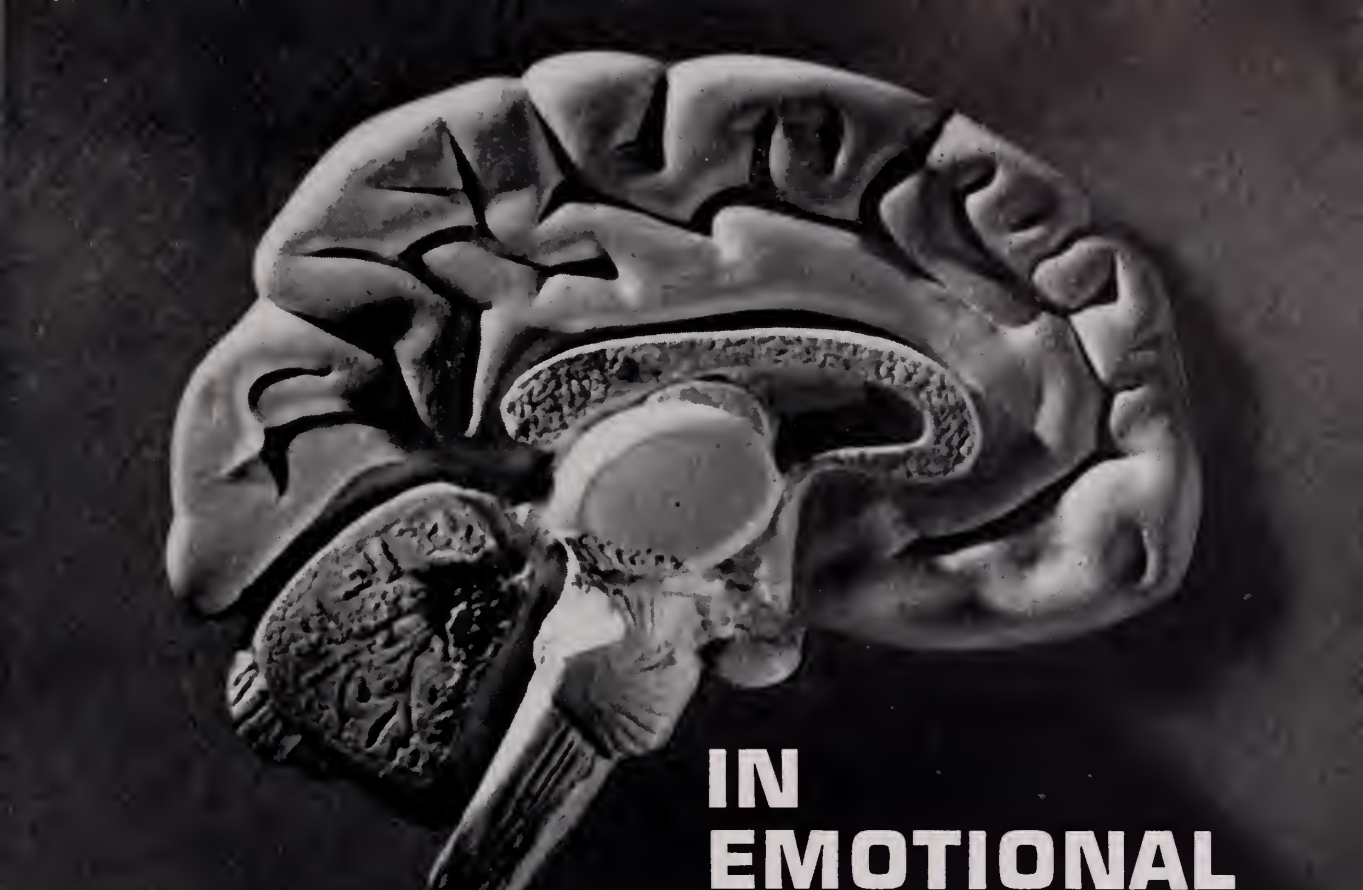
Many physicians are surprised by the high doses of Thorazine (chlorpromazine, SK&F) used in patients released to their care from mental hospitals. This surprise may be expressed by a drastic reduction in dosage "to play it safe"—with serious consequences for the patient.

The successful maintenance of former mental patients requires adequate, often "high" dosage, and often for prolonged periods of time. Fortunately, these dosages do not mean greater risks for the patient. On the contrary, there is much less risk of serious side effects once a patient has become gradually accustomed to Thorazine (chlorpromazine, SK&F)—*regardless of dosage*—over a period of a few months. Continuing therapy is almost always well tolerated, and is essential to most patients' continued well-being.

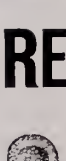
Brief Summary: Thorazine (chlorpromazine, SK&F) has been successfully used for 10 years in the treatment of mental and emotional disturbances, and has proven highly effective in the maintenance therapy of former hospitalized mental patients. *Principal side effects:* The most frequently encountered side effect is transitory drowsiness. Other occasional side effects include: dry mouth, nasal congestion, constipation, miosis, dermatological reactions, photosensitivity, jaundice, hypotension, increased appetite and weight; very rarely, mydriasis, agranulocytosis, extrapyramidal symptoms. *Contraindications:* Comatose states or in the presence of excessive amounts of C.N.S. depressants.

For complete prescribing information, please see *PDR* or available literature.

SK&F *Smith Kline & French Laboratories*

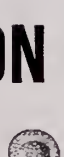


RELIEVES ANXIETY, APPREHENSION AND TENSIO



All day long

. . . keeps the patient calm, and the mind clear.



All night too

. . . aids restful sleep, with no barbiturate hangover.

MEPROSPAN®-400

(MEPROBAMATE 400 MG. SUSTAINED RELEASE)

Simplified, convenient dosage for emotional relief.

Side effects: 'Meprospan' (meprobamate, sustained release) is remarkably free of untoward reactions. Daytime drowsiness has not been reported. Rare allergic or idiosyncratic reactions may occur, generally developing after 1-4 doses of the drug.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage ma produce lethargy, stupor, ataxia, coma, shock, vasomotor a respiratory collapse. Consider possibility of dependence, pa ticularly in patients with history of drug or alcohol addictio withdraw gradually after prolonged use at high dosage.

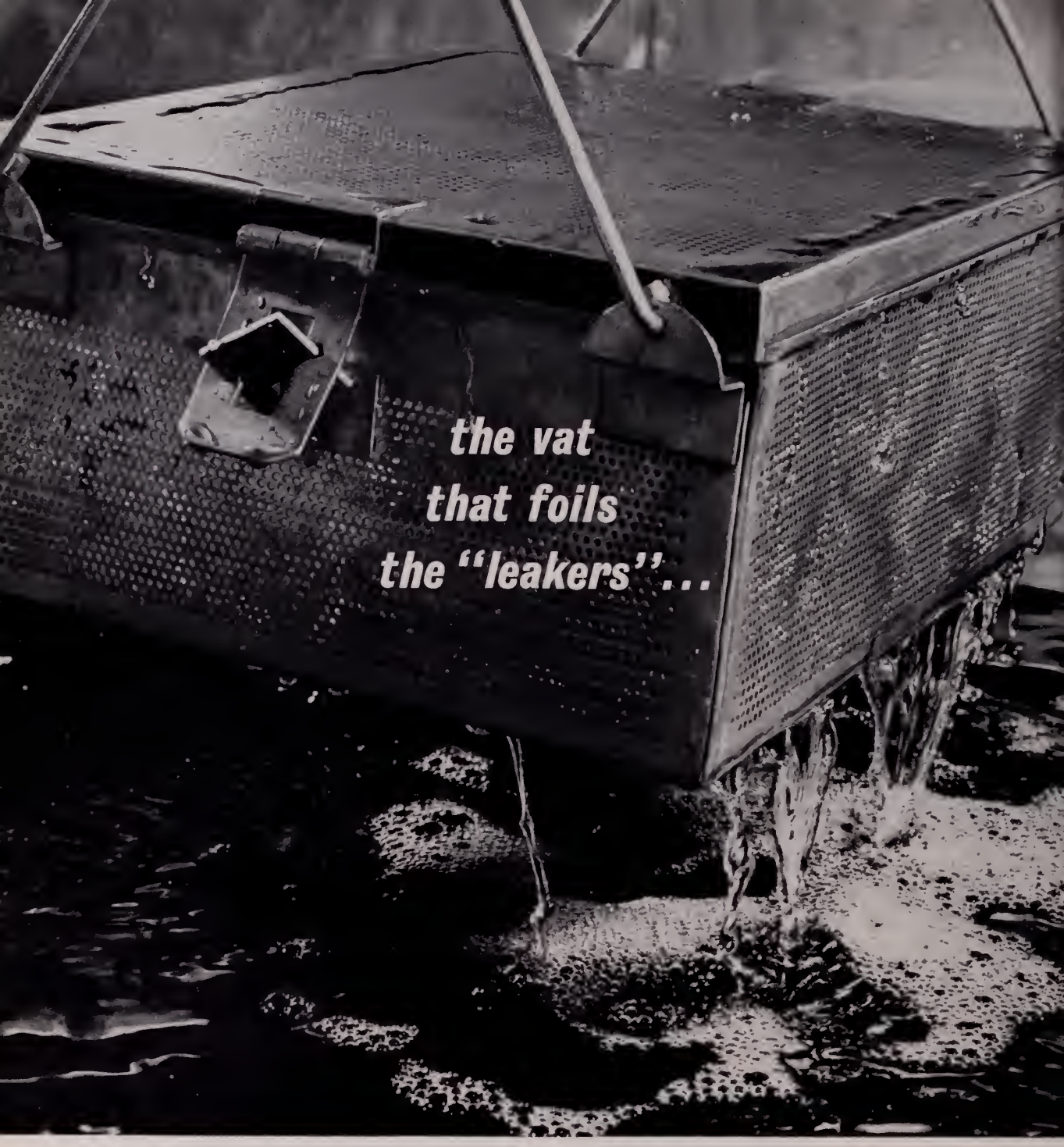
Complete product information available in the product pac age, and to physicians upon request.

Usual adult dosage: One 400 mg. capsule or two 200 m capsules at breakfast; repeat with evening meal.

Supplied: 'Meprospan'-400 (meprobamate 400 mg.), 'Mepr span'-200 (meprobamate 200 mg.), each in sustained-relea capsules. Both potencies in bottles of 30.

CME-1969

WALLACE LABORATORIES *Cranbury, N. J.*



"Leakers" are ampoules with minute imperfections in the seal. You can't readily see the flaw, and often it's so small that liquids won't even drip through; but microscopic contaminants can slip in to render the contents nonsterile and potentially dangerous. ▪ Detecting "leakers" is the job of the vat and the blue dye. ▪ Sealed Lilly ampoules are placed in baskets, submerged in a vat containing methylene blue, and subjected to a vacuum. If there is an imperfect ampoule in the lot, the liquid is forced out. When the vacuum is released, the blue dye rushes in. ▪ With dye as the spy, elusive "leakers" are quickly spotted and rejected . . . another of the many controls that add immeasurably to the quality of the finished product.

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The JOURNAL
of the Florida Medical Association

Perinatal Mortality

A Pilot Study at Jackson Memorial Hospital

Gunnard J. Antell, M.D., Marjanne H. Crino, M.D.,
and Denis Cavanagh, M.D.
MIAMI

Maternal and infant mortality has long been a topic of interest and study in the United States. In 1958 the American Medical Association became concerned about the continued high rate of perinatal mortality. It was noted that during the preceding 15 years, maternal mortality had gradually fallen to less than 1,500 deaths a year, a 77 per cent reduction in the mortality rate. During this same period, the perinatal mortality rate, composed of fetal and neonatal death rates, had decreased at a much slower pace. Stillbirth and neonatal deaths still accounted for nearly 180,000 deaths per year, this figure representing only a 22.6 per cent reduction. As a result, the Committee on Maternal and Child Care of the Council on Medical Services of the American Medical Association founded the Medical Research Foundation for Perinatal Study.

The aim of the Medical Research Foundation for Perinatal Study is "to improve the production of normal human beings by the elimination of deaths and damage during the process of reproduction."[1] The Foundation hopes to achieve this goal by means of research, education and service.

In 1961, the first year of its existence, only a limited number of hospitals throughout the country were involved in the A.M.A. study. Each subsequent year, however, additional hospitals were included as funds became available. At the present time, 500,000 case records are being analyzed. All tabulations are made with Univac machines and the study is supervised by Dr. Sidney Kane, a Philadelphia pediatrician.

In January 1962 the Departments of Obstetrics-Gynecology and Pediatrics of the University of Miami School of Medicine at Jackson Memorial Hospital entered the study. A grant in support of the work was obtained from the Florida State Board of Health. Further support was obtained from the Florida Pediatric Society, the Miami Obstetrical and Gynecological Society and the Miami Pediatric Society. The purpose of supporting the study at Jackson Memorial Hospital was to determine the feasibility of urging the adoption of the A.M.A.'s perinatal mortality study in all Florida hospitals. It was reasoned that if the study could be carried out successfully in the largest obstetrical unit in the state, and without direct House Staff participation, it would be practical to urge the introduction of the study in all other hospitals.

The source of data for this study included the completion of a 90 column I.B.M. code sheet on every private and staff patient delivered at the Jackson Memorial Hospital during 1962. The information was readily available from the required delivery room log, properly completed patients' charts which included an adequate prenatal record, and infants' charts. With a few days of training, the time required to complete one of these code sheets was less than five minutes. At Jackson Memorial Hospital, the code sheet was begun on the day of delivery and completed when the mothers were discharged. In the case of a premature infant or perinatal death, the code sheet was held until the infant was discharged and/or the pathology report was available. One person, working on a daily part time basis at Jackson Memorial Hospital with the assistance of a clerk for week-end deliveries, was able to handle the study without difficulty and without any direct assistance from either Resident or Attending Staff.

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Read before the Florida Pediatric Society, Hollywood, May 18, 1963.

Definition of Terms

In the A.M.A. study, fetal death or stillbirth is defined as a death occurring in any infant weighing 501 Gm. or more, which takes place prior to complete delivery from the mother. Neonatal death applies to any infant weighing 501 Gm. or more, born alive but dying during the first 27 days of life. In this report "Perinatal Period II" is used as the basis for analysis. This includes all infants weighing 501 Gm. or more.

Statistical Analysis

During 1962, 4,603 infants were delivered at Jackson Memorial Hospital. This number included not only those delivered in the Labor-Delivery Unit but also infants delivered in the Emergency Room or elsewhere in the hospital. There were 750 private (16. 3 per cent) and 3,853 (83.7 per cent) Staff deliveries. In Jackson Memorial Hospital, the Staff service is made up primarily of economically underprivileged Negro and white patients. When analyzed by race, 2,205 (47.9 per cent) were Negro and 2,398 (52.1 per cent) were white patients. The latter group contained several oriental and Indian patients. Of the total deliveries, 2,730 (59.4 per cent) were spontaneous, requiring no operative assistance except for episiotomy. Of these, 2,704 were vertex and 26 were breech presentations. Forceps without rotation accounted for 1,261 (27.4 per cent) of the total number of deliveries. Also included in this group were those babies who required manual rotation prior to the application of forceps for delivery. Forceps rotation was necessary in 197 (4.3 per cent) cases.

Cesarean sections were performed on 267 patients, giving a cesarean section rate of 5.8 per cent. The primary section rate accounted for 3.2 per cent and the repeat rate for 2.6 per cent. Our cesarean section rate of 5.8 per cent is somewhat higher than the 4.6 per cent national average. Our higher rate is accounted for by the larger number of obstetrical complications seen at this hospital.

Table 1. — Presentation at Delivery

Occiput anterior	3,921 (85.2%)
Occiput posterior	226 (4.9%)
Occiput transverse	99 (2.2%)
Breech, frank	141 (3.1%)
Breech, other	65 (1.4%)
Other	151 (3.2%)
Total	4,603

An analysis of the deliveries by presentations is shown in table 1. An analysis of neonatal deaths by the more common presentations is given in table 2. It will be noted that about 10 per cent

Table 2. — Neonatal Deaths by Presentation

Occiput anterior	58 (58.6%)
Occiput posterior	3 (3.0%)
Breech, frank	10 (10.1%)
Breech, footling	7 (7.1%)
Total	78

of neonatal deaths resulted from a frank breech presentation even though only about 3 per cent of all presentations were from this position. A secondary point to note is that about 7 per cent of all neonatal deaths resulted from footling breech even though only 1.4 per cent of all presentations were from this position. Thus, the footling breech presents an even more serious obstetrical problem because of the greater tendency to prolapsed cord. Thus, in reviewing presentation at delivery of those infants who died during the neonatal period, it was noted that close to 18 per cent of those deaths occurred after breech deliveries, although breech deliveries accounted for only 4.5 per cent of the total number of deliveries. The management of breech presentations in the second stage of labor depends on skillful handling by an experienced and trained obstetrician. This serious obstetrical problem, if correlated with the philosophy of breeches mentioned, can be the determining factor in decreasing the mortality rate associated with this malpresentation.

The infant mortality rates are given in table 3. The stillborn rate is determined by subtracting the neonatal mortality rate from the perinatal mortality rate. It has been stated that the stillborn rate should approximately equal the neonatal mortality rate if proper reporting is being done. In this case, it is nearly exactly 50 per cent.

Table 3. — Infant Mortality

Stillbirth rate	21.0/1,000
Neonatal death rate	21.6/1,000
Perinatal death rate	42.6/1,000
Autopsy rate	39.8%

The autopsy rate of 39.8 per cent can be explained by the fact that infants under 1,000 Gm. are ordinarily not autopsied at Jackson Memorial Hospital.

There were 548 live premature infants delivered, giving a prematurity rate of about 12 per cent. An analysis of neonatal mortality by weight is given in table 4. This study is not concerned with infants weighing 500 Gm. or less.

According to ideal hospital statistics,[2] one would expect a death rate of 95 per cent in the 501-1,000 Gm. group; 65 per cent in the 1,001-

Table 4. — Neonatal Mortality Related to Weight

Weight	Live Deliveries	Premature Mortality
500 Gm. or less	3	100%
501-1,000 Gm.	38	89%
1,001-1,500 Gm.	52	44%
1,501-2,000 Gm.	130	11%
2,001-2,500 Gm.	325	2%
	548	

1,500 Gm. group; 25 per cent in the 1,501-2,000 Gm. group; and 10 per cent in the 2,001-2,500 Gm. group. When we compare our premature mortality rate by weight with the national statistics, it comes out very favorably. This result we owe to the excellent care given at the Premature Center in the Department of Pediatrics. According to a recent study by The National Foundation,[3] an estimated 7 per cent of all newborns have one or more congenital anomalies. Roughly then, one would multiply the total number of live births by 0.07 to obtain an estimate of the number of babies with congenital anomalies.

The most frequent causes of neonatal deaths in our series are given in table 5. In the list of deaths by cause, 45 deaths out of a total of 196 perinatal deaths were listed as "undiagnosed."

Table 5. — Most Frequent Neonatal Deaths by Cause

Cause	Number
Multiple anomalies	5
Atelectasis	7
Hyaline membrane	8
Bronchopneumonia	8
Prematurity	9
Undiagnosed	45

In these cases, no cause of death was apparent at autopsy, or no autopsy was performed.

On a national basis, of 4,878 neonatal deaths studied, 1,774 were described in the respiratory system; 1,050 in the urogenital system; and 888 were undefined.

The perinatal mortality rate for Jackson Memorial Hospital was 42.6/1,000 as compared with 28/1,000 for the remainder of the South Atlantic Region. It should be noted, however, that Jackson Memorial Hospital delivered a much larger proportion of "Staff" patients, the comparative figures being 83.7 per cent here, as compared with 30.7 per cent average from the South Atlantic Region. The percentage of "Staff" patients in each region of the United States studied, and the perinatal mortality rate for each region are given in table 6. It is sad to note that Region "A", which includes Puerto Rico, has a perinatal mortality rate of 52.2/1,000. This is by far the highest perinatal mortality rate, being twice that of most of the other nine regions. It may also be noted, however, that this is the only region in which 100 per cent of the patients studied are listed as "Staff." The inference to be drawn is not that these patients receive poor care, but that the high perinatal mortality rate is the inevitable product of a poor environment.

Table 6. — Perinatal Mortality by Region of the United States

Region	Staff	PNMR
1. New England	7.2%	23.6
2. Middle Atlantic	16.7%	25.3
3. South Atlantic	30.7%	28.0
4. East-North Central	26.1%	28.2
5. East-South Central	27.2%	34.5
6. West-North Central	9.1%	23.3
7. West-South Central	20.5%	23.4
8. Mountain	5.8%	25.2
9. Pacific Northwest	14.1%	22.2
10. "A"	100.0%	52.2

Summary

A pilot perinatal mortality study was carried out in the Departments of Obstetrics-Gynecology and Pediatrics of the University of Miami School of Medicine at Jackson Memorial Hospital in 1962.

The purpose and mechanism of collection of data are outlined, the period of study being from Jan. 1, 1962 through Dec. 31, 1962.

Data from 4,603 deliveries at Jackson Memorial Hospital were collected and analyzed.

Average-sized hospitals need very little additional help in the tabulation of data.

With the A.M.A. Perinatal Study it appears that accuracy is high because methods and mechanism of collection of data are centralized.

Perinatal mortality and premature mortality rates obtained are compared with regional and national statistics.

The introduction of this system of reporting and collecting of data would lead to a more careful study of all maternal and fetal complications in all Florida hospitals. This should produce improvement in maternal and child care.

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3. Memorandum, National Foundation, May 8, 1963.

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Surgical Repair of Large Lower Eyelid Defects

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Large full thickness eyelid defects have special requirements for reconstruction. A review of this subject is presented with illustrative cases.

Requirements

1. Anterior layer—skin
2. Posterior layer—mucous membrane

The eyelid is surgically divided into two layers or lamellae. Full thickness lid repair requires filling the skin defect in the anterior lamella with free or sliding skin grafts. The posterior lid layer lies against the cornea. Corneal ulceration will occur unless the posterior layer is lined with nonkeratinized mucous membrane. Grafting lost eyelashes is not necessary for normal eyelid function. Vertical lid support is gained by postoperative fibrosis within the two reconstructed lid layers.

Methods of Repair

2. Mucous membrane graft on skin pedicle (Spaeth)[1]
2. Sliding skin flap (Reese)[2]
3. Tarsal-conjunctival flap from upper lid (Hughes)[3]

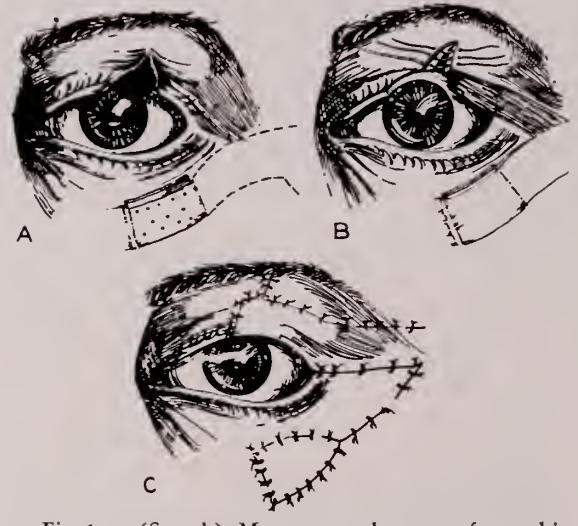


Fig 1. — (Spaeth) Mucous membrane graft on skin pedicle. (See text)

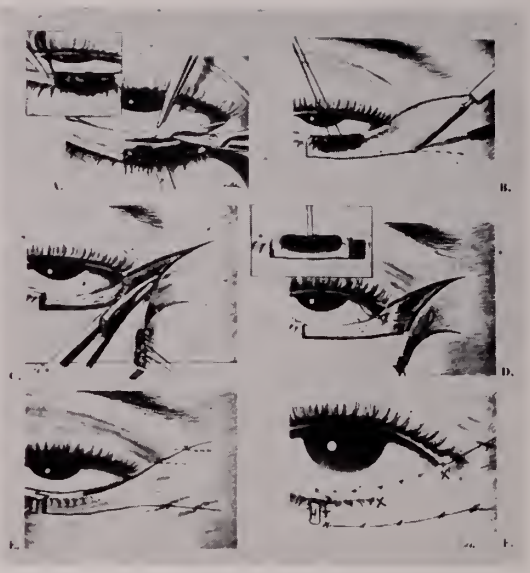


Fig. 2.—(Reese) Sliding skin flap. (See text)

Spaeth's method (fig. 1) illustrates the use of a skin pedicle to fill a defect in the upper lid. A free mucous membrane graft is grafted beneath the head of a skin pedicle. At a second stage, the defect in the lid is tailored, and the skin pedicle with the mucous membrane graft is brought into the defect, shaped to fit, and sutured appositionally. The donor site for the skin pedicle is closed by sliding flaps, or a free skin graft. This method is used least frequently because of the multiple stages involved, high infection rate, and inability to control entropion.

Reese's procedure (fig. 2) consists of sliding a skin flap, based temporally, into the lid defect. Figure A shows that the posterior layer is conserved by splitting the lid just below the margin. Although this is not a full thickness eyelid defect, it is usually possible to mobilize sufficient conjunctiva from the lower cul-de-sac to line the posterior surface of the temporally based skin pedicle.

Reese's operation is probably the most frequently used method for reconstructing lower lid defects. It is especially useful in older patients where wrinkles hide the extensive scar that is created. Entropion of the lower lid is a problem with this technique.

Hughes' method (fig. 3) of sliding a tarsal-conjunctival pedicle flap from the upper lid is the best method. It gives consistently good results

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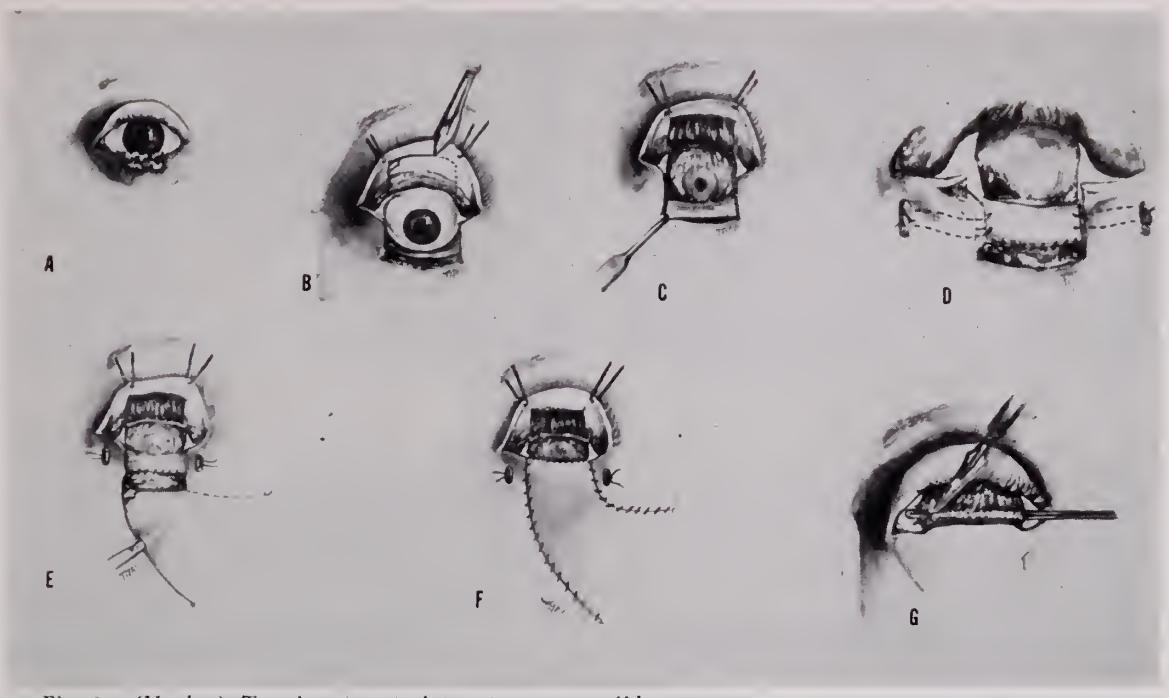


Fig. 3.—(Hughes) Tarsal-conjunctival flap from upper lid.

A. Tumor of the lower lid requiring full thickness lid excision.
B. Upper lid everted. Construction of tarsal-conjunctival pedical flap.
C. Pedicle flap pulled down over the cornea into the lower lid defect.
D. Conjunctiva from the lower fornix mobilized upward and sutured to the lower border of tarsus from the upper lid. Tarsus then anchored to remaining lower lid with tongue-in-groove sutures tied over rubber pegs.
E. Sliding skin flap mobilized from the cheek.
F. Skin flap advanced into lower lid defect and sutured to skin and tarsal-conjunctival pedicle.
G. Opening the lids by cutting the tarsal-conjunctival pedicle and trimming the excess.

and can be modified to fill all lower and most upper lid defects. The steps in the procedure are outlined below the drawing. Loss of lashes and entropion of the upper lid occur unless the tarsal incision is made 4 mm. from the upper lid margin. Dissection should remain in the plane of Müller's muscle, so that the levator muscle is not advanced during construction of the tarsal-conjunctival pedicle. Since there is redundant conjunctiva in the upper fornix, no functional loss of conjunctiva in the upper lid occurs when the tarsal-conjunctival pedicle is excised. If the lid defect is in the nasal or temporal one third of the lower lid, the tarsal flap must be anchored to the periosteum. After the cornea has been covered by the tarsal-conjunctival flap, either a free or sliding full thickness skin graft is used to fill the skin defect.



Case I (Fig. A).—Basal cell carcinoma confined to mid one third of the lower lid involving the margin and fixed to tarsus. Full thickness block excision with a 4 mm. margin on each side and below the tumor was performed with conservation of the lower puncture and canaliculus.



Case I (Fig. B).—The result with the tarsal-conjunctival pedicle from the upper lid and a sliding skin flap advanced from the lower lid into the defect.



Case 1 (Fig. C).—Final result. Note minimum cosmetic defect due to absence of lower lid lashes.



Case 3 (Fig. G).—Final result after full thickness excision with 4 mm. margin around the tumor.



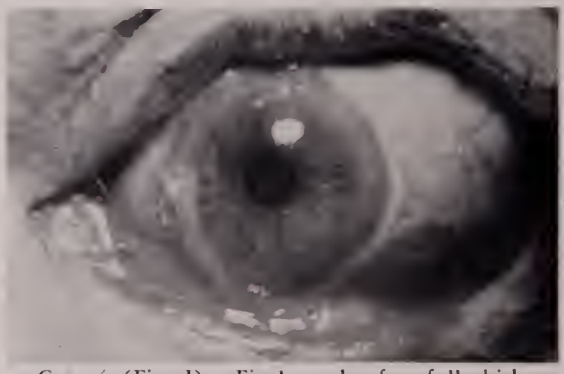
Case 2 (Fig. D).—Basal cell carcinoma, mid one third of the lower lid involving the margin and tarsus.



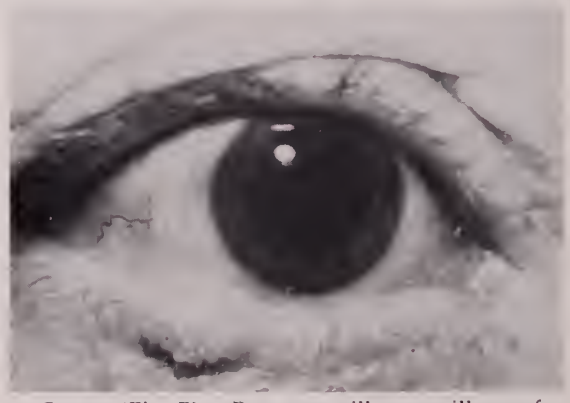
Case 4 (Fig. H).—Recurrent basal cell carcinoma involving the margin and tarsus with extension onto the punctum.



Case 2 (Fig. E).—Final result after full thickness block excision with 4 mm. margin around the tumor. Lacrimal system was preserved.



Case 4 (Fig. I).—Final result after full thickness excision including lower canaliculus. This illustrates the rim of mucous membrane in the reconstructed lower lid.



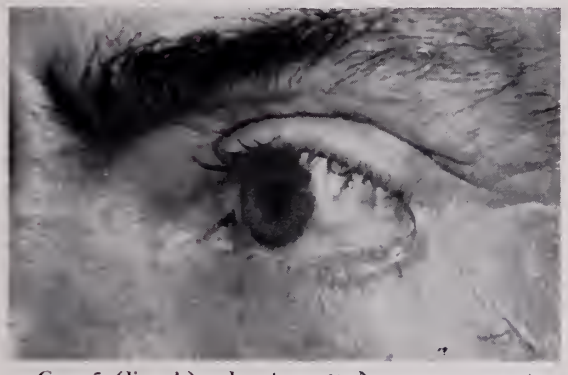
Case 3 (Fig. F).—Recurrent villous papilloma after simple excision.



Case 5 (Fig. J).—Basal cell carcinoma involving the skin and tarsus in the outer one third of the lid. Full thickness lid excision with 4 mm. margin involved loss of the lower limb of the lateral canthal ligament.



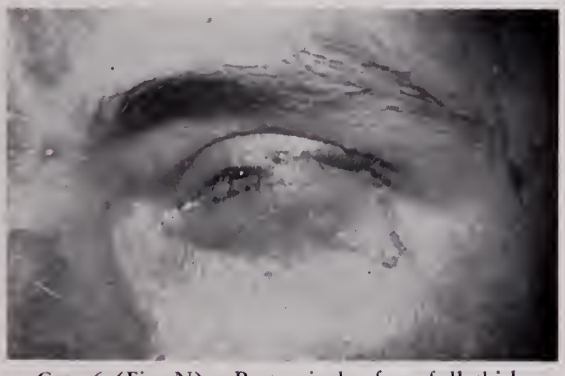
Case 5 (Fig. K).—Tarsal-conjunctival pedicle and sliding skin flap in place, with reconstruction of the lower limb lateral canthal ligament.



Case 5 (Fig. L).—Final result. Note some rounding of the lateral canthus.



Case 6 (Fig. M).—A heavily pigmented nevus involving both layers of the upper and lower eyelid and lid margin.



Case 6 (Fig. N).—Postauricular free, full thickness skin graft on a tarsal-conjunctival pedicle from the upper lid.



Case 6 (Fig. O).—Final result. Note cosmetic effect of eyebrow pencil instead of lash graft.

Split thickness grafts contract excessively and result in ectropion. The best sites for full thickness eyelid skin grafts are the opposite upper eyelid and behind the ear.

The grafts are left in place from one to six months. The length of time depends upon softening the skin graft to insure against contracture and distortion of the lid after severing the intermarginal adhesion. Loss of vision from the involved eye for this period is a disadvantage of this procedure.

Sacrificing the nasal one third of the lower lid involves loss of the lacrimal apparatus with occasional postoperative tearing. Excision of the palpebral lobe of the lacrimal gland usually results in control of excess tears.[4] The accessory lacrimal glands in the conjunctiva lubricate the cornea.

While this procedure is used most frequently following excision of eyelid tumors, general surgeons may have occasion to use this method in the emergency repair of a totally avulsed eyelid. Illustrative cases using this technique are presented.

Summary

The requirements for repair of full thickness lower eyelid defects are presented. Various methods of repair using transposition of local flaps are discussed. Hughes' method utilizing a tarsal-conjunctival pedicle flap from the under surface of the upper lid, and a full thickness skin graft overlying it, is advocated. Examples of repair are presented.

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The Changing Role of the Otolaryngologist in Tuberculosis

Evaluation of Antibiotics in Hearing Impairment

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Those of us who have entered the field of tuberculosis during the second quarter of this century have witnessed a vast change in the character of the bodily infection by the tuberculosis bacilli and in the methods of treatment. Phthisis pulmonis has been known for many centuries. Since the otolaryngologist has for his field the upper segment of the respiratory tract with its contagious organisms, I will review how he has been affected by these changes.

Formerly, tuberculosis of the ear, nose, and throat was seen during the active stage of the disease, and was believed to be due to a miliary spread or to bacilli-laden sputum coming in contact with a break in the mucous membrane. The tubercles which formed, coalesced and broke down, forming superficial spreading gray ulcers, made the disease a wretched one, causing the patient pain in talking and swallowing. The development of the lesions was hastened because of the malnutrition brought about by the failure to eat, due to dysphagia. The treatment was as painful as the disease. In an attempt to halt the extension of the ulcers, various medications were applied to the ulcerated areas, in most instances without success. Since the other lesions usually healed only with healing of the pulmonary lesion, the best that could be done was to lessen the pain by the application of local anesthetics.

In active pulmonary tuberculosis, the larynx was involved in about 10 per cent of the cases, and not infrequently the laryngeal lesion led to the diagnosis of the pulmonary infection. The lower portions of the respiratory tree, which the otolarygnologist would invade, are the trachea and bronchi. The trachea was involved usually in the terminal stages of the pulmonary disease. Not so the bronchi, in which granulations and ulcerations leading to bronchostenosis were common. These lesions were then treated by the use of silver nitrate as the cauterizing agent. The stenotic areas were dilated in order to promote better bronchopulmonary drainage. The various methods of collapse therapy, such as artificial pneumothorax, pneumoperitoneum, or thoracoplasty, were employed in most of the cases, but the results were poor in spite of repeated bronchoscopies, which did not aid in the comfort of the patient.

Chemotherapy was first used generally in 1947 with drugs such as streptomycin, followed by dehydrostreptomycin and PAS (paraaminosalicylic acid) in 1950; in 1952 INAH (isonicotinic acid hydrazide) was added. In 1957 viomycin was used in cases where the bacilli had developed resistance to the earlier drugs. Pyrazinamide came into use in 1958 and cycloserine in 1959. The picture changed radically both for the phthisiologist and the otolaryngologist. As far as the former was concerned, pneumothorax, pneumoperitoneum, and thoracoplasty for collapse of involved lung tissue were employed less and less. Resection of the affected pulmonary tissue, early ambulation, and lessened length of hospital stay became common.

Following the introduction of the antimicrobial agents, the otolaryngologist no longer saw the manifestations of tuberculosis to which he had become accustomed. There were no longer "active" tuberculous lesions in his field, or if so, very rarely was an endobronchial tuberculous lesion seen. The few that still were encountered in newly discovered cases of pulmonary infection healed rapidly and completely with chemotherapy; local measures were not necessary. The drop in the number of cases of tuberculous endobronchial disease, tuberculous laryngitis, and tuberculosis of the ear, nose, and throat has been much greater than in the pulmonary cases.

Have the antimicrobial drugs severed the pleasant and mutually useful relationship between the chest specialist and the otolaryngologist? Not at all. While these antibiotics are most effective against Mycobacterium tuberculosis, many are toxic to the structures within the temporal bone. Although most of these drugs have been well investigated, there is, even among otologists, some

confusion regarding several important aspects of their ototoxic properties. By obtaining an audiogram and testing the vestibular reaction before using these agents, one establishes a baseline so that testing performed during their administration will disclose early signs of toxicity. In that way, the dosage of the drugs may be reduced, the drug may be discontinued entirely, or another drug may be substituted before severe damage to the inner ear structure occurs.

Five antibiotics are in use regarding which the problem of ototoxicity is of particular concern. They are chemically related, each being composed of a combination of sugars with an organic base. The group is made up of streptomycin, dehydrostreptomycin, neomycin, viomycin, and kanamycin.

Streptomycin, as is well known, is particularly toxic to the vestibular system. Glorig and Fowler[1] pointed out that the vertigo experienced by the patients receiving streptomycin is of an unusual type. Blurring of vision is a frequent and early complaint. In their series some patients also experienced ataxic gait, similar to that associated with acute alcoholism. Most patients with vestibular injury adjust over a relatively short period of time, usually in less than three months. In some instances, however, the symptoms persist and may be troublesome for many months or even years.

Dehydrostreptomycin is much more likely to cause hearing loss than streptomycin, and less likely to cause vestibular disturbance. It is a most dangerous drug and, in susceptible persons, as little as a total of 1.5 to 2.0 Gm. can cause irreversible, permanent, handicapping, sensorineural deafness.

Neomycin is now rarely used parenterally. Early clinical trials showed the drug to be severely ototoxic, principally to the auditory nerve, as well as nephrotoxic. Carr and his associates[2] reported the development of severe deafness in four out of six patients who received 0.925 Gm. to 1 Gm. of neomycin every 12 hours for four to six weeks. Waisbren and Spink[3] reported deafness in five out of 63 patients who received 1.5 to 2.0 Gm. of neomycin daily for four to 16 days. The parenteral use of this drug is, therefore, now rarely justified.

Viomycin is used almost exclusively in tuberculosis therapy. In clinical use, it has produced both cochlear and vestibular damage. In the second viomycin conference, Amberson[4] estimated that in 20 to 30 per cent of some 200 patients who had received viomycin an impairment of hearing had developed in the high frequencies, and in three patients total deafness was reported.

Kanamycin, which closely resembles neomycin in chemical structure and antimicrobial activity, is severely ototoxic, particularly for the cochlea. In a study[5] at Bellevue Hospital, New York, in approximately one third of the patients receiving daily therapy hearing loss had developed after 60 Gm. of kanamycin, and in more than two thirds after 120 Gm.

In spite of chemotherapy, there are many residuals of the pulmonary infection, such as bronchiectasis and bronchostenosis. Bronchoscopy and bronchography are used to demonstrate these and in many cases the need for resectional surgery is shown. Fibrosis in the mediastinum produces pressure on the recurrent laryngeal nerve, resulting in voice changes and, on occasion, in paralysis of the vocal cords. Breaking down of mediastinal lymph nodes may involve these nerves also. Fibrotic changes in the upper lobe of the left lung may involve the left recurrent laryngeal nerve, resulting in hoarseness.

In spite of the changing role from that of treating active tuberculous lesions to that of preventing damage by the use of antimicrobial agents, the otolaryngologist still plays an important part in the treatment of pulmonary diseases. As new and more effective agents are developed, he, in all probability, will be needed to detect their ototoxic effects. There will, therefore, be a perpetuated relationship. For my part, this role has been most interesting and rewarding.

Comment

It has been claimed by several investigators that a combination of streptomycin or dehydrostreptomycin with pantothenic acid reduces the toxic effects of these antibiotics. Several others have, however, been unable to substantiate these findings.

It is remarkable that the antibiotics which are most effective against the Mycobacterium tuberculosis are also toxic to the inner ear. This response probably occurs because of some similarity between the enzyme septums of the cells of the end organs and of the bacteria. So far, we have little knowledge of what this similarity may be.

A question that arises is: Can an ototoxic antibiotic sensitize the ear so that it becomes more liable to injury by other ototoxic antibiotic as a

later course of therapy by the same drug? There is some evidence suggesting that this may be so, but it has not been proved.

Any new antibiotic with a chemical structure similar to that of the ototoxic antibiotics will require careful evaluation for ototoxicity. Experience has shown that the finding in animals may differ substantially from that in humans. Consequently, it is necessary to take particular care in early chemical trials of potentially ototoxic drugs to avoid serious damage to the ear.

References are available from the author upon request.

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Symptomatic Treatment of Bronchial Asthma With A New Antiasthmatic Drug Combination

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Bronchial asthma in its many manifestations is a distressing and serious disorder. Palliative relief is imperative for two reasons. One is the distressing symptoms which incapacitate the patient and keep him in the fear and agony of suffocation for hours. The other reason is that repeated attacks of asthma leave their mark on lung tissue.

Prolonged and untreated courses of asthma decrease the compliance and elasticity of the respiratory organ. These changes are irreversible. The picture of the emphysematous patient with a long history of bronchial asthma is a familiar one. That is why most clinicians regard early and symptomatic relief for the juvenile asthmatic urgent.

Since the pathogenesis of allergic asthma and hay fever is as yet unknown, no truly specific therapeutic agent is available. Although the overall results of management of asthma by allergists, when available, are gratifying, yet the actual cure rate at best is only approximately 20 per cent of the cases.[1] Symptomatic management with theophylline, antihistamines, and sympathomimetic amines alone and in combination has been employed with varying results.[2] Therapeutic evaluation, however, is difficult because of the many variables of the allergy, patients, and side effects. Because of side effects and relative shortness of action, many of these preparations require repeated administration in small doses. This is particularly bothersome in treating children and the active adult.

Recently a time-release preparation, Dilamin*, containing 25 mg. of methylethylamino-phenylpropanol hydrochloride, 60 mg. of theophylline aminoisobutanol, and 6 mg. of doxylamine succinate has been made available. A single Dilamin tablet provides adequate protection and relief for six to eight hours, making round-the-clock therapy relatively easy.

Materials and Methods

Dilamin was used in the treatment of 59 patients, ranging in age from four to 76 years, who had asthma and other allergies. These patients, when first seen at the office, had not responded satisfactorily to conventional medical treatments. They were given Dilamin for symptomatic relief until such time as more specific methods, such as diet elimination and hyposensitization, would have a chance to have effect. They were selected to receive Dilamin in the hope that this new time-release preparation would be able to relieve them of their symptoms.

The group consisted of 23 males and 36 females. Twenty-four (40.7 per cent) were under 17 years of age. A history of the disease and previous treatment, as well as complete examinations

*Dilamin, product of Walker Laboratories, Inc., Mount Vernon, N. Y.

and laboratory tests, was recorded for each patient. All were found to be suffering from bronchial asthma; in 51 of the 59 patients the condition was diagnosed as chronic. Other concomitant disorders were allergic conjunctivitis and allergic rhinitis.

The prescribed Dilamin dosage and frequency varied with the severity of the condition and the individual response of each patient. In the adult group of 35 patients, the effective dose for 16 patients (45.7 per cent) was one Dilamin tablet administered twice daily; nine patients (25.7 per cent) required two tablets twice daily; three received two tablets once daily; six were given three tablets daily; and only one patient needed three Dilamin tablets three times a day.

In the group of 24 younger patients (under 17 years of age), the effective dosage for 17 patients (70.8 per cent) was one Dilamin tablet twice daily. Five patients (20.8 per cent) required one tablet three times daily, but two patients (8.3 per cent) obtained satisfactory relief from only one Dilamin tablet nightly.

Results

An extremely gratifying response to Dilamin medication was observed in most patients. Forty-seven (80.0 per cent) of the 59 patients obtained good to excellent relief of symptoms. Only one patient (1.7 per cent) failed to benefit from Dilamin therapy. The response to Dilamin medication was even more favorable in the group of 24 younger patients; 21 (87.5 per cent) of these patients reported excellent to good results. The remaining three reported that they obtained a fair relief from Dilamin.

Since the majority of the patients had been suffering from chronic bronchial asthma, a large variety of drugs, including the steroids, had been administered previously. Such patients are usually good judges of what medication has given them relief, and their subjective evaluation is a fairly reliable indication of a drug's efficacy. When asked how Dilamin compared with the previous symptomatic medications they had received, 38 (70.9 per cent) of 55 respondents replied that Dilamin was better. Again, the younger patients found Dilamin more effective than those in the older age group. Eighteen (81.8 per cent) of 22 of them preferred Dilamin to any previous medication.

Side effects were at an absolute minimum. Only one patient, a 32 year old man, stated that two tablets at bedtime made him sleepy. The one patient who did not benefit by the medication did not complain about side effects. On the other hand, one child who used to become quite "nervous" after receiving ephedrine preparations did not show any such symptoms with Dilamin.

Summary

Dilamin, a time-release combination of methylethylamino-phenylpropanol hydrochloride, theophylline aminoisobutanol and doxylamine succinate was administered to 59 patients, the majority of whom had chronic bronchial asthma. All of the patients were first seen in the office and had not responded to conventional treatments by a regular physician. They ranged in age from four to 76 years; 24 were under 17.

Dilamin was found to be most effective in relieving the distressing symptoms of these patients. The most effective dose was one or two tablets twice daily. Forty-seven (80.0 per cent) of the 59 patients obtained good to excellent relief. When asked how Dilamin compared with the previous symptomatic medication they had received, 70.9 per cent reported that Dilamin was superior.

The results obtained by the patients under 17 years old were better than those reported by the older patients. Twenty-one (87.5 per cent) of the 24 younger patients reported excellent to good results and 81.8 per cent preferred Dilamin to any previous medication.

Side effects were almost absent. Only one patient, a 32 year old man, stated that two tablets at bedtime made him sleepy.

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1. Swineford, O., Jr.: Discussion on Asthma, The Allergic Patient 4:4 (May) 1963.
2. Bernstein, C., and Klotz, S. D.: Treatment of Asthma, J. A. M. A. 157:811-814 (Mar.) 1955.

303 East Par Avenue.

Winstrol

To construct a building is much more difficult than to tear one down. So is it with the human body. Winthrop, however, does offer an anabolic agent, STANOZOLOL, which is claimed to help the build-up of body protein and tissue. See page 208.

President's Page

Foreword

Birthdays and anniversaries are the usual occasions for retrospection and plans for the future. It was my feeling that better evaluation and more objective thoughts concerning progress of the Florida Medical Association would be obtained from one who has been prominently identified with the organization through many years, and who maintains, presently, his enthusiastic interest, with active participation. Dr. Jere W. Annis, with characteristic generosity and talent, responded to my request with the editorial: "The Old Lady Shows Her Medals." You will find it brilliant in concept, most interesting in content, and provocative as a challenge for all of us to keep working.

Warren W. Quillian, M.D.
President

The Old Lady Shows Her Medals

Although complacency is never justified, certainly there are times when a degree of self satisfaction in reviewing one's recent accomplishments may be pardonable. This is especially so when, amidst the vagaries of existence, the progress and achievements of a life so completely dwarf its failures and disappointments, as they do in the case of the remarkable matriarch I have just had the opportunity of interviewing.

This grande dame, on her Ninetieth Birthday, has the enthusiasm and the sparkle of an adolescent—and the courageous confidence that delights in the challenge of today and tomorrow. I found this little old lady—the Florida Medical Association—stealing a moment of relaxation from the midst of a hectic, harassed life of conflict and criticism, and quietly reflecting on her recent accomplishments—her medals of the last five or six years. As we talked, an impressive list began to fill my notebook:

There was the renovation of the entire administrative structure of the Association, with the creation of departments of Legislation and Public Relations, and there was a similar professional reorganization with a completely new Constitution and By-Laws;

The modus operandi of the House of Delegates had been modernized and made more efficient under the direction of a Speaker and Vice Speaker.

An eminently successful and productive annual meeting of Presidents and Secretaries of the County Medical Societies had been instituted, and the Association's office had extended its services to the specialty societies within the state, aiding them in keeping books, rosters and mailing lists and in preparing routine reports;

An investment plan for the benefit of all Physicians within the state had been established;

A handbook for County Medical Societies—a much needed ready reference for County Society Officers—had been published and was in great demand;

The home office building itself had been enlarged and expanded. Two large river-front lots immediately behind the building had been acquired for future expansion and investment;

A widely comprehensive insurance program had been instituted and had grown until at present it covers all fields of insurance protection necessary to the practicing Physician;

Especially commendable was the growth and fruition of a statewide indigent care program involving both HSI and Kerr-Mills legislation—a program conceived and developed by Dr. Hampton and his Committee, and copied nationally;

The lady pointed with particular pride to the improved relationship with our political representations in Tallahassee and those in Washington, and felt that the establishment of an active Key Contact Physicians Committee, with its annual trip to Washington each March, had played a major part in this accomplishment and in keeping our national representatives conversant with the opinions and the feelings of Florida's Physicians;

Amongst the many professional accomplishments, the visual screening program, now involving a good portion of the state at large, was noteworthy;

And in the more mundane area of fiscal responsibility there were the monumental, tireless, unselfish efforts of the much-maligned Fee Schedule Committee which have resulted in a Florida Relative Value Schedule, successfully negotiated Medicare contracts, and progress with the solution of the difficult Workmen's Compensation problem which, with patience and indulgence on the part of the Physicians in the state, appears headed toward a successful conclusion.

Quite an impressive list—enough, perhaps, to soothe the bruises of disappointment and the bumps of bitterness that have been incurred along the way—as her roistering family, flexing its ever restless muscles, has grown apace, and has challenged the country at large to better Medicine—better discipline of Physicians—and better citizenship.

We must, I think, respect this Mother of ours and credit her with an excellent day's work, allowing her the satisfaction of reasonable pride in these recent successes —successes that must surely lead the way to the continued advancement of the Science and the Art of Medicine.

Not a bad record, old girl—not a bad record!

Jere W. Annis, M.D.



Editorials

Reflections On the Sixtieth Annual Congress On Medical Education

It was my privilege to represent the Florida Medical Association at the Sixtieth Annual Congress on Medical Education, presented by the Council on Medical Education of the American Medical Association, in Chicago on February 9 and 10, 1964. Interest in the meeting was manifested by the fact that the Grand Ballroom of the Palmer House was comfortably filled at every session. In the audience were deans of a number of medical schools and directors of medical education of many hospitals. It would be interesting to discuss each of the 21 papers individually, but obviously it is impossible to do so in a report of this kind; so I will endeavor to condense it and give the gist of the material as I interpreted it.

The morning session of February ninth was devoted to the Basic Medical Sciences and discussed were the manner in which medicine emerges from many sciences, the changing distribution of basic medical sciences in medical schools and the interfaces between these sciences and their university roots and clinical branches as viewed by the basic scientist and the clinician. It was brought out that half of the curricula of medical schools today are involved in the basic sciences and the gulf between them and the clinical departments is gradually disappearing. It was thought they provide the lifeblood to the clinical fields. It was not until the turn of the nineteenth century that it was no longer necessary for a member of the faculty of a medical school to have an M.D. degree. The holder of a double degree is not necessarily a superior teacher, but it is desirable to integrate the basic sciences into the clinical departments and good basic medical science teachers should have some medical orientation. A somewhat revolutionary concept was advanced that there be an amalgamation of the colleges and universities, each one accepting only those students for which it was particularly specialized to teach. It was suggested that universities cease being all things to all people.

The interfaces of the basic sciences were discussed and it was stated that these are caused by the fact that faculties in these departments are homogeneous groups, as are those in clinical departments, each group content within itself and insecure when in the company of the other. To reduce these interfaces, it was advised that more young medical graduates should be encouraged to enter the basic science fields, salary differentials should be abolished and both departments share common meeting places with more curricular and departmental integration. The clinical phase of the program stressed that the practice of medicine is taking the facts of scientific medicine and making them work, and wisdom, judgment and experience are still essential for good practice. The clinician in a limited field may be proficient also in the basic science involved in this field and must be able to interpret and apply this knowledge. A plugged catheter may account for an apparent anuria as well as a kidney shutdown.

The afternoon was spent in discussing "Continuing Medical Education." This centered around the public's and profession's concern for professional competence. It was brought out that the public is better educated in medical matters and in a better position to judge medical competence. Organized labor believes the consumer can evaluate the quality of medical care. Lay hospital boards are scrutinizing more closely the outside medical activities of the staff and medical audits are utilized to determine the excellence of care. Built-in methods by which the profession judges the ability of its own members, beginning with the

American Medical Association, ranging through state and speciality boards and ending with various hospital staff committees, were enumerated. A nationwide plan for continuing medical education was explained. There are now 1,264 approved postgraduate courses given annually. A central exchange would be available to the 1,500 teaching hospitals. This exchange would have a governing body and act as a national collecting agency for all modalities, as video tape, used in postgraduate teaching. There are 82 educational television stations in the country that can be used for dissemination of knowledge. It was stated by a psychiatrist that an emotional overlay is the principal difficulty in 50 per cent of patients seen in practice. The availability of postgraduate courses in psychiatry, sponsored by the Committee on Psychiatry and Medical Practice of the American Psychiatric Association, was explained. These courses have been utilized by about 10 per cent of the doctors in the areas where given. It was admitted that many psychiatrists use a poor consultation technique and need a broader medical knowledge. One opinion expressed was that continuing medical education was too little and too late. To circumvent this, the novel suggestion was made that every practicing physician remain an integral part of his medical school. The result would be that he would remain a part of the university and the university a part of him.

The morning session of February tenth was allotted to the "Town-Gown Syndrome" relating to the tensions between medical schools and private practice. These tensions were freely admitted and several specific instances were recited where they were only partially resolved by outside committees free of prejudice. The lack of referral of private patients to hospitals connected with medical schools was mentioned and it was thought that both patients and teaching hospitals were harmed by this attitude of private practice. The problems began with the employment of full time faculties resulting in a sheltered group versus a more exposed one in private practice, bureaucratic versus individualistic attitudes, liberalism versus conservatism, receiver of taxes versus payer of taxes, politically quiet versus politically active groups and both competing for the same class of patients. With the differentiation between service and pay patients disappearing, this tension is apt to increase unless steps are taken to reduce it. To accomplish this objective, both groups must recognize the causes of these tensions. These may be helped by continuing medical education of faculties of medical schools, adequate facilities for patients of private practitioners, active participation of faculty members in medical societies and well functioning liaison committees between the medical schools and county and state medical societies.

The subject of the afternoon program was "The Internship." The evolution of internship was traced from its beginning with the first house staff in the Pennsylvania Hospital in 1761. In 1913, 50 per cent of medical graduates took an internship. In 1919, 17 states required internship for licensure while this is necessary in 37 states today. There were 77 medical schools in 1940 and 87 in 1963 with 7,300 graduates. The National Intern Matching Plan was begun in 1951 and the Internship Review Committee in 1954. In 1963, there were 12,199 available internships which were 73 per cent filled and 37,000 residencies 80 per cent filled. The present status of internships is in a state of flux. There is some question of its validity and some feeling that it is merely a duplication of clerkship in the senior medical school year. This view is held particularly in teaching hospitals where the work of interns is done by first year residents. The internship of the future in affiliated hospitals will be the straight one. Straight internships are on the increase while rotating internships are on the decline and mixed ones have made a slight gain. A report of a two year rotating internship at the University of Rochester Medical Center was given. This was designed for general practitioners, but surprisingly enough none of the 124 graduates, who began it, entered general practice. Six months each were given in medicine, pediatrics and psychiatry with three months of surgery and obstetrics and gynecology. A large number of this group entered psychiatry as a specialty, undoubtedly because of the inspirational leadership of the head of that department.

It was stated that the assets of the community hospital in intern training are the liabilities of the teaching hospital and vice versa. The advantages of the community hospital were given as orientation of good care of the sick, also in clinical medicine and private practice, close relationship with senior physicians, respect for economic aspects of medicine, less degree of departmentalization, benefit from continuing patient care relationship and inculcation of good patient-physician relationship. The liabilities are time restriction imposed on the attending staff, special privileges

for those who teach, failure to provide incentive to teach, unwieldiness of large staffs, lack of advanced diagnostic and therapeutic techniques, lack of research facilities, lack of big-named physicians on the staff and lack of glamour and prestige.

A report was received from the National Board of Medical Examiners on the results of Part II and III examinations as applied to internships. A larger percentage of graduates with the highest grades on Part II examinations went to affiliated hospitals for their internship rather than community hospitals. The stipend or size of the hospital did not affect the quality of the graduate applying for internship. At the termination of the internship year, applicants for Part III examinations from community hospitals showed the same competence as those from teaching hospitals with an adjusted allowance for the difference in their grades in Part II examinations. Interns from hospitals with the highest stipends showed lesser competence on Part III examinations than those from hospitals with lower stipends. Those completing straight internships did equally as well as those from rotating ones.

I regarded the Congress as enlightening and informative, even though I thought a few of the ideas advanced were a bit radical. The basic medical sciences are assuming an increasingly important role in medical education and rightfully so. There is no doubt that research is the lifeblood of medicine. It seems important though to recognize the end point at which a proper balance can be maintained. Progress must be made carefully, retaining the best of the past and accepting the contributions from research of clinical application that will broaden our horizons of the future. Differences between medical schools and private practice must be resolved for each provides an important segment of medical care. We are fortunate in Florida in having the leadership in both areas to provide a cordial relationship. Postgraduate training in teaching hospitals appears to be increasingly slanted to the training of specialists. The economy and geographical variants in this country will not permit the elimination of the general practitioner in the foreseeable future. It appears that he must turn to the nonaffiliated hospitals in the future for the rotating internships to complete his training. This trend is probably good because it will provide him with the more intimate type of patient care that is necessary in his field of practice.

In conclusion, I think that the Congress on Medical Education is an important annual event because it acts as a forum to bring into the open problems in medical education that will continue to arise and which require the thoughtful consideration of intelligent physicians for the preservation of the high standard of medical care in this country.

And so, this observer, after two full days of sitting, listening and taking notes, feeling virtuous and coccyx-conscious, returned home where he is proud to be an insignificant bit of a medical complex that is providing the finest type of state and national leadership.

CHARLES J. COLLINS, M.D.
ORLANDO

Declomycin

We have heard a great deal about the longer cigarette. In DEMETHYLCHLORTETRACYCLINE, we have a longer antibiotic. Blood levels which are claimed to be prolonged beyond that expected with other tetracycline derivatives characterize this product. See page 263.

Old and Still Good

It is true that for the last 25 years we have been living in the era of "wonder drugs;" sulfonamides, steroids, antibiotics, and tranquilizers. This development has benefited humanity enormously. It has, however, also shown some of us that there still exists a number of drugs which outdate the new therapeutic era, and are widely used to this day. In other words, they must have "given satisfaction" or they would have disappeared, as did the majority of older products.

Now let us look at some important ones in that category which "stood the test of time." The first one perhaps that comes to mind is good old aspirin. It has been used since 1899. Later it became an ingredient in the APC formula and in these days it is a standard part of the various antihistaminics plus APC as found in Emprazil-C tablets.

Those who teach pharmaceutical chemistry could probably quote at least one or two dozen of far more recent drugs which might have taken its place. One also may quote from the literature of these would-be competitors a number of arguments why aspirin might be supplanted. The medical profession, however, must have had satisfactory results with it since the drug is still very much in vogue. Its use is especially impressive if one considers that the American medical profession is usually anxious to try out the latest—and presumably best—advances in chemotherapeutic agents. If one considers that the life of many of our modern "wonder drugs" lies between three and five years, 64 years of aspirin use does sound impressive.

Those who have used the services of health officers in our embassies in Africa and Asia have seen that the "middle-aged" pre-wonder-drug Kaopectate enjoys apparently "official" favor to help recently arrived Americans to overcome the onslaught of intestinal troubles in those areas. The drug itself—developed in 1935—has been honored by endless duplications, including in the National Formulary. All types of drugs have been added to the simple formula, but, despite the absence of promotional efforts, it simply kept on being used, and now is even widely used in veterinary medicine also. Perhaps the additive properties (physically speaking) of the two ingredients, both obtained from natural sources, are sufficient to eliminate gastric troubles while at the same time there is a total absence of any possibility of toxic or even side effects. Oddly enough, all the many duplications, plus all sorts of modern wonder drugs, seem to have influenced its use by physicians very little. This observation also holds good in many foreign countries.

We now come to a whole group of ancient drugs which still commands high standing. I am referring to the group of digitalis glycosides. Attempts to replace them with squill glycosides, having similar cardiotonic actions, never did cause excitement among physicians despite efforts of several pharmaceutical manufacturers. The only real change was the switch from powdered leaf to the various pure digitalis glycosides. This took place 30 to 35 years ago, and apparently no further change has been found to be necessary in the field of cardiotonics.

Despite the advances in the field of the treatment of anemias, Lextron still is widely used, obviously because of its clinical effectiveness.

The number of new drugs for use as an intestinal sedative is large, but paregoric—an ancient preparation indeed—still commands respect. Even now it is in the United States Pharmacopeia, and one might wager it will be used for a long time to come.

Of course, natural drugs are disappearing more and more, but some have been found so effective that they have a sizable group of admirers today. Think of cascara, belladonna, balsam of tolu, ipecac, castor oil, colchicine and cod liver oil. Again, there are modern equivalents for all of them, but the drugs—as old as they are—have demonstrated their effectiveness, and side reactions, if any, have been fully explored. By the way, in the case of good old phenobarbital, we had exactly such an example. In 1948 an excellent synthetic was developed to take its place. It did not give any of the unpleasant barbiturate side effects. Alas, after several months, the Federal Drug Administration ordered its removal from the market, because of two cases of granulocytosis due to its use. This condition cannot be anticipated at present, and therefore, no fault lies with the manufacturer. So, phenobarbital will be in use for many years to come.

Another interesting group are the botanical drugs used for centuries which recently were

shown to be valuable. While in America nobody used Rauwolfia, in India it was used for centuries, and of course, the European physicians smiled at the "single-minded" Asiatics. Then we got reserpine and rescinnamine out of the drug, and now everybody wonders how Western medicine could have missed the drug for so long.

Powdered thyroid is still preferred by many physicians over the isolated two chief chemicals found in the thyroid gland, despite all the promotional endeavors of the drug industry.

Of course, when it comes to cough remedies, one should expect many older drugs still to be favorites, such as Cheracol, Cosanyl, and others. Actually, they do as well as any of the newer ones, and medical men know a great deal about their actions based upon years of experience with them.

Since aspirin was first introduced in 1899, thousands and thousands of pounds have been consumed yearly. Not like other drugs whose use is decreased with age, aspirin has had increased use with age. In combination with caffeine and phenacetin, it has made a wonderful cold combination and a good all-round analgesic. This cold combination has now been improved by the addition of a decongestant and an antihistaminic. This combination is found in Emprazil-C tablets which also contain 15 mg. of codeine phosphate.

Werner M. Lauter, Ph.D.
Professor of Pharmaceutical Chemistry
College of Pharmacy, University of Florida
Gainesville

This editorial was contributed by invitation in keeping with The Journal's current emphasis on its advertisers and their drug products.

Space Psychiatry Tidbits

The term "space psychiatry" in this formulation is used to encompass concepts, principles and applications of psychosocial biology. It pertains not only to deviations of behavior and personality functioning from the norm, by virtue of outer space conditions, but also to the capitalization of human constructive potentialities integrated with an ever expanding universe.

A realistic cosmic consciousness stems from experiencing macrocosmic adaptations. These involve interplanetary and interstellar interrelationships with earth-bound man seeking and embracing outer space phenomena.

The process of discovering man's relatively new role in scouting the challenges of various facets of time-space continuum may hatch breakthroughs of knowledge making for aerospace navigation and conquests. Such revelations could evolve a better way of life on new planes of existence. There is also the probability of life, even human life, on myriads of other planets.

This quest is basic for man's survival in this competitive world of opposing ideologies with avowals of "burying" the opposition. It is also essential for his continuing infinite growth and development possibilities.

Projects now being developed for lunar exploration, as well as those for investigating Mercury, Venus, Mars, Jupiter, Saturn and other planets, are token indications of man's concern for his future and the solution of the challenges and opportunities they present.

A genetic-dynamic determined new perspective, with a vision of infinite and unpredictable ultimate achievements for human betterment, must keep us adequately motivated if we are to enjoy the triumphs of growing success emerging.

A better understanding of the worlds without man will further the conquest of the world within man. They are mutually related and interdependent. A pluralistic monism should be kept in mind.

A new look, a panoptic aeroflight view of our world, past, present and future, buttressed with adequate research, is needed to fulfil man's optimum potentials.

Space psychiatry, with effective collaboration of other scientific disciplines, is desirable to give deeper meaning, higher purposes, values, and satisfaction in our search for new horizons for the abiding benefit of all mankind.

Frederick L. Patry, M.D.
Bradenton

Synopsis of an address to the Woman's Auxiliary to the Florida Medical Association, Fall Conference, St. Petersburg, Oct. 15, 1963.

Major Medical Health Insurance

Major medical health insurance is the latest advance in health insurance offered to our citizens by commercial insurance companies. At present over 38 million Americans have some form of major medical health insurance. This type of policy provides financial protection against lengthy and expensive hospital stays, extensive nursing and medication in or out of the hospital, complicated surgery, or costly treatment by non-surgical specialists. In most policies the only limit on individual items is that they be "reasonable charges for necessary services."

These policies contain:

(1) A deductible provision to eliminate small claims and the administrative expense associated with them.

(2) A co-insurance clause which gives the patient a direct financial interest in each dollar of medical or hospital care ordered for him. As a general rule, the insurance company's share above the deductible portion is limited to 75 to 80 per cent of the expenses, with the patient paying the remaining 20 to 25 per cent.

There are two fairly common interpretations of "usual and customary" as determined by insurance companies:

(1) The usual and customary fee in the community of a physician of comparable training, skill and caliber.
(2) The usual and customary fee in the community of a physician of comparable training, skill and caliber for a patient of comparable financial resources, exclusive of insurance. This interpretation is adhered to by most insurance companies.

As to the matter of "comparable financial resources," it is important for a reviewing committee to determine whether the coverage is by an individual or a group major medical contract. If it is an individual contract, the usual and customary fee will be higher for individuals with a higher income. If it is a group policy and the high-salaried executives pay the same premium as the other employees, then the usual and customary fee will be the same for both groups. If, however, the high-salaried executives carry a higher deductible or a lower co-insurance rate, then the usual and customary fee will be higher for these executives than the other employees in the group.

Mr. Albert V. Whitehall, Vice-Chairman of the Health Insurance Council of America, recently stated that the core of the problem in relation to major medical health insurance is that some doctors refuse to understand the concept of "covered charges" and "reasonable and customary fees." This places the companies in a position of having to explain to their policyholders why they do not always allow the doctors' full fee as a "covered charge."

Major medical health insurance, considered desirable for the medical profession since it eliminated the fixed-fee schedule, has created additional problems:

(1) The medical profession did not anticipate the frequency with which doctors' charges would deviate from the statistical average or customary norm reflected in the relative value fee schedule. Traditionally many doctors have had a range of fees for the same procedure with the over-all spread between the high and low fee sometimes being over 100 per cent.

(2) The medical profession did not recognize that the public would become increasingly aware of what the customary or "going rate" was. More and more patients and companies would begin to question the fee in each instance where it was above the "customary level." After working on this problem for four years in Broward County, we believe that the public's principal objection to the present method of determining doctors' fees for services is the mystery and uncertainty of charges. The development of relative value fee schedules has begun to clarify and to some extent stabilize physicians' fees in various parts of the United States. In these areas the public has become informed and some guidelines have been made available to it, so that it might pass an informed judgment of medical costs. These areas have displayed a strong support for the present method of the private practice of medicine.

Because of an increasing interest by organized medicine in various parts of the United States to take some of this mystery out of our charges:

(1) The Alameda-Contra Costa Medical Association in California will back up the patient if there has not been a prior agreement to exceed the set fee (relative value schedule). The society's

Fee Complaint Committee does not arbitrarily apply the relative value charge, but uses this guide in deciding what a reasonable charge should be. If the offending doctor refuses to reduce his fee, the society will give the patient a letter stating what the usual charges for the particular medical procedure are in the county. This letter would make it extremely difficult for the physician to collect the extra charge through legal action if the patient refuses to pay.

(2) The Association of Minnesota Internists has stated that "while the doctor would be able to charge more or less than the medical society's schedule, the maximum liability of insurors ought to be geared to the amount determined from the medical association's schedule with a fixed conversion factor. Any excess charges would not be insured and would have to be worked out between the doctor and the patient."

(3) The Massachusetts Medical Society's Committee on Medical Charges to Pooled Funds has stated: "If it appears that the person or institute and the patient have agreed in advance upon the amount of fee, such an agreement can fix contractual rights and liabilities as between these contracting parties, but it cannot govern the rights or obligations of the insuror. An insuror could not lawfully contract so that the amount of its liability would be fixed by whatever amount a person or organization rendering the services to an insured might decide to charge."

In summary, it is our opinion that the medical profession would be well advised to begin taking the public into its confidence in establishing fairly exact standards of professional charges and fees. This approach will strengthen and maintain public confidence in our profession. We must not look to the insurance profession to establish these standards; this is our job and a part of the collective doctor-patient relationship. Major medical health insurance is the best insurance yet offered to the medical profession and the public, and we make the following recommendations to help guide our Florida physicians:

(1) Include the type of insurance coverage in fee discussions with your patients. Most patients will appreciate this frank discussion as it often helps to alleviate the financial worries associated with illness.

(2) Learn all you can about voluntary health insurance and its effects on medical economics.

(3) Cooperate with your local Voluntary Health Insurance Review Committee and bring to it your problem insurance cases.

(4) Understand that a verbal contract with your patient does not necessarily obligate a third party (insurance company) to honor this contract. It will pay the usual and customary fee for the type of contract, specialty involved, and your patient's financial resources. In unusual and complicated cases, attach a narrative report supporting your higher than usual fee.

(5) Fill out insurance forms as rapidly as possible, preferably within two weeks. Do not refuse to fill out a form because the patient still has an outstanding bill.

(6) Use your Florida Relative Value Studies for guidance in deciding on a "usual and customary" fee. Specialty groups may agree regionally upon an acceptable conversion factor for use in association with the Florida Relative Value Studies to help standardize these fees.

(7) Ask your local hospital chief-of-staff to appoint a Utilization Committee in your hospital to help reduce the spiraling cost of medical care. Your local county medical society will assist you in this important activity if asked to do so.

David J. Lehman Jr., M.D.
Fort Lauderdale

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SPEAKERS FOR NINETIETH ANNUAL MEETING MAY 7-10, HOLLYWOOD



Dr. Hutchinson



Dr. Smith



Dr. Guild



Dr. Whorton



Dr. Freeman

Dr. William M. Hutchinson, Jacksonville, "Urological Aspects of Pyelonephritis;" Dr. Richard T. Smith, Gainesville, "Pyelonephritis as a Developmental Problem;" Dr. Warren R. Guild, Boston, "Practical Points Regarding Pyelonephritis." Dr. C. Merrill Whorton, Jacksonville, member of the Panel. Dr. Oscar W. Freeman, Orlando, Moderator.



Dr. Baker



Dr. Nyhan



Dr. Gardner



Dr. Litt

Dr. Thomas J. Baker, Miami, "Congenital Cysts of the Newborn;" Dr. William L. Nyhan, Miami, "Developmental Aspects of Osteomyelitis in Children;" Dr. Ernest D. Gardner, Detroit, "The Developmental Aspects of the Skeletal System with Reference to Skeletal Abnormalities." Dr. Richard E. Litt, Miami, member of the Panel. Dr. Howard A. Pearson, Gainesville, Moderator. (Dr. Pearson's photograph not available.)



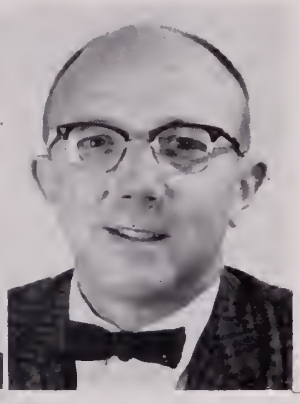
Dr. Altman



Dr. Cordes



Dr. Andersen



Dr. Pickett

Dr. Donald H. Altman, Miami, "Radiological Diagnosis in Surgical Emergencies of the Neonate;" Dr. John H. Cordes Jr., St. Petersburg, "Recognition of Surgical Emergencies in the Newborn;" Dr. Thorkild W. Andersen, Gainesville, "Anesthesia for the Newborn;" Dr. Lawrence K. Pickett, Syracuse, N. Y., "Surgical Aspects of Neonatal Jaundice." Dr. Albert H. Wilkinson Jr., Jacksonville, Moderator.



Dr. Wilkinson



Dr. Ferguson



Dr. Bone



Dr. Wolff



Dr. Manry

Dr. Emmet F. Ferguson Jr., Jacksonville, "Functional Gastrointestinal Disorders and the Surgical Patient;" Dr. Frank C. Bone, Orlando, "A Physiologic Basis for Functional Gastrointestinal Disturbance;" Dr. Theodore M. Wolff, Miami, "Psychiatric Aspects of Functional Gastrointestinal Disorders." Dr. Williard E. Manry Jr., Lake Wales, member of the Panel. Dr. Donald F. Marion, Miami, Moderator.



Dr. Marion


Dr. Doff


Mr. Orsini


Mr. Cotton


Dr. Hampton

Dr. Simon D. Doff, Jacksonville, "Medical Economics—Alternatives to Hospital Care;" Mr. Lou Orsini, New York, "The Role of the Voluntary System in Medical Care Cost Conservation;" Mr. Horace Cotton, Southern Pines, N. C., "Economic Yardstick for Physicians." Dr. H. Phillip Hampton, Tampa, Moderator.


Dr. Taylor


Dr. Barnard


Dr. Dever

Dr. G. Dekle Taylor, Jacksonville, "Man in the Aquatic Environment," (film presentation); Dr. George W. Barnard, Gainesville, "Psychological Adaptation of Man to Unusual and Stressful Environments." Dr. Richard C. Dever, Miami, Moderator.

Wednesday, May 6

9:00 a.m.	Set Up Exhibits	Hotel Convention Hall
2:00 p.m.	Registration Desk Opens	Foyer, Hotel Convention Hall
2:00 p.m. to 4:30 p.m.	Registration of Delegates	Corridor Hotel Convention Hall

Thursday, May 7

8:00 a.m. to 9:30 a.m.	Registration of Delegates	Corridor Hotel Convention Hall
9:30 a.m.	First Session, House of Delegates	Hotel Convention Hall
11:00 a.m.	Annual Meeting Blue Shield	Hotel Convention Hall
2:00 p.m.	First Scientific Assembly	Hotel Convention Hall

Friday, May 8

8:00 a.m.	Board of Past Presidents Breakfast	Sky Room (Lower)
9:00 a.m.	Scientific Film Program	Hotel Convention Hall
	Reference Committee No. 4	Card Room
9:30 a.m.	Reference Committee No. 3	Tack Room
10:00 a.m.	Reference Committee No. 2	Embassy Room (West)
10:30 a.m.	Reference Committee No. 1	Embassy Room (East)
11:00 a.m.	General Session (President's Guest Speaker)	Hotel Convention Hall
2:00 p.m.	Second Scientific Assembly	Hotel Convention Hall
6:30 p.m.	President's Reception	Poolside (Alt. Rear Lobby)

Saturday, May 9

All Day	Meetings of Specialty Societies	

Sunday, May 10

8:00 a.m. to 9:30 a.m.	Registration of Delegates	Corridor Hotel Convention Hall
9:30 a.m.	Second Session, House of Delegates	Hotel Convention Hall
12:00	Adjournment	
1:00 p.m.	Post-Convention Board of Governors Meeting, Luncheon	Embassy Room
	Florida Medical Foundation	Embassy Room

SCHEDULE OF ACTIVITIES

FLORIDA MEDICAL ASSOCIATION ANNUAL MEETING

Hotel Diplomat, Hollywood-by-the-Sea, May 7-10, 1964

Wednesday, May 6

9:00 a.m.	Set up Exhibits	Convention Hall
2:00 p.m.	Registration Desk Opens	Corridor Convention Hall
2:00-4:30 p.m.	Delegates' Registration	Corridor Convention Hall

Thursday, May 7

All Day	Registration and Exhibits	Convention Hall
All Day	Woman's Auxiliary Hospitality Room	Mezzanine Room 200A
8:00-9:30 a.m.	Delegates' Registration	Corridor Convention Hall
9:30 a.m.	First House of Delegates Session	Convention Hall
11:00 a.m.	Blue Shield Annual Meeting	Convention Hall
1:00 p.m.	Woman's Auxiliary, Registration and Board Meeting	Mezzanine Theatre
2:00 p.m.	Florida Medical Association Scientific Section Meeting	Convention Hall
3:30 p.m.	Florida Medical Association Scientific Section Meeting	Convention Hall
4:00 p.m.	Woman's Auxiliary Interview Hour	Mrs. Wilcox' Suite
8:00 p.m.	Florida Association of General Surgeons, Scientific Film Program	Mezzanine Theatre
8:00 p.m.	Florida Society of Internal Medicine, Council	Sky Room Lower
8:00 p.m.	Florida Cancer Council	Mezzanine Room 200B

Friday, May 8

All Day	Registration and Exhibits	Convention Hall
All Day	Woman's Auxiliary Hospitality Room	Mezzanine Room 200A
8:00 a.m.	Board of Past Presidents, Breakfast	Sky Room Lower
8:00 a.m.	Woman's Auxiliary Registration	Mezzanine Theatre
9:00 a.m.	Scientific Film Program	Convention Hall
9:00 a.m.	Woman's Auxiliary House of Delegates	Mezzanine Theatre
9:00 a.m.	Reference Committee No. 4	Card Room
9:30 a.m.	Reference Committee No. 3	Tack Room
10:00 a.m.	Reference Committee No. 2	Embassy (West)
10:30 a.m.	Reference Committee No. 1	Embassy (East)
11:00 a.m.	General Session (President's Guest Speaker)	Convention Hall
12:00 noon	Committee on Scientific Work, Luncheon	Sky Room Lower
12:30 p.m.	Woman's Auxiliary Annual Luncheon	Les Ambassadeurs
2:00 p.m.	Florida Medical Association Scientific Section Meeting "Surgical Diseases of the Newborn"	Convention Hall
2:00 p.m.	Florida Medical Association Scientific Section Meeting "Functional Disorders of the Gastro-intestinal Tract"	Mezzanine Theatre
3:00 p.m.	Woman's Auxiliary Membership Meeting	Mrs. Wilcox's Suite
6:30 p.m.	President's Reception	Poolside (Alt. Rear Lobby)
7:30 p.m.	Alumni and Fraternity Groups	

Saturday, May 9

All Day	Registration and Exhibits	Convention Hall
All Day	Woman's Auxiliary Hospitality Room	Mezzanine Room 200A
7:30 a.m.	Florida Society of Internal Medicine, Council, Breakfast	Mezzanine Room 200D
8:00 a.m.	Florida Pediatric Society, Executive Committee	Card Room
8:00 a.m.	Florida Urological Society, Executive Committee	Seminar Room 3
8:30 a.m.	Florida Society of Anesthesiologists, Board of Directors	Card Room Diplomat West
9:00 a.m.	Florida Chapter, American College of Surgeons, Business and Scientific	Convention Hall
9:00 a.m.	Florida Orthopedic Society, Business and Scientific	Cafe Cristal
9:00 a.m.	Florida Society of Ophthalmology and Otolaryngology, Scientific	Embassy Room
9:00 a.m.	Florida Radiological Society, Scientific	Mezzanine Theatre
9:00 a.m.	Florida Health Officers' Society, Business and Scientific	Mezzanine Room 200B
9:00 a.m.	Florida Academy of General Practice and Florida Society of Physical Medicine and Rehabilitation, Scientific	Rumpus Room East
9:00 a.m.	Florida Society of Pathologists, Business	Seminar Room 2
9:00 a.m.	Florida Obstetric and Gynecologic Society, Business	Card Room, Diplomat Inn

9:00 a.m.	Woman's Auxiliary Board Meeting	Nassau Room, Country Club
9:00 a.m.	Florida Society of Internal Medicine, Business	Les Ambassadeurs
9:30 a.m.	Florida Urological Society, Business	Seminar Room 3
9:30 a.m.	Florida Society of Dermatology	Seminar Room 1
10:00 a.m.	Florida Pediatric Society, Scientific	Card Room
10:00 a.m.	Florida Obstetric and Gynecologic Society, Scientific	Card Room, Diplomat Inn
10:00 a.m.	Florida Allergy Society, Business	Sky Room Lower
10:15 a.m.	Florida Society of Anesthesiologists, Business	Card Room, Diplomat West
10:30 a.m.	Florida Urological Society, Scientific	Seminar Room 3
11:00 a.m.	Florida Association of General Surgeons, Business and Scientific	Convention Hall
12:00 noon	Florida Society of Ophthalmology and Otolaryngology, Buffet Luncheon	Mezzanine Lounge
12:00 noon	Florida Society of Dermatology, Luncheon	Rumpus Room East
12:00 noon	Florida Society of Internal Medicine, Dutch Treat Luncheon	Les Ambassadeurs
12:30 p.m.	Florida Society of Physicial Medicine and Rehabilitation, Luncheon	Mezzanine Room 200C
12:30 p.m.	Florida State Surgical Division, International College of Surgeons, Luncheon	Tack Room
12:30 p.m.	Florida Chapter, American College of Chest Physicians, Luncheon and Business	Calcutta Room, Country Club
1:00 p.m.	Florida Society of Ophthalmology and Otolaryngology, Business	Embassy Room
1:00 p.m.	Florida Society of Pathologists, Scientific	Seminar Room 2
1:00 p.m.	Florida State Surgical Division, International College of Surgeons, Business	Tack Room
1:00 p.m.	Florida Society of Plastic and Reconstructive Surgery, Business and Scientific	Mezzanine Room 200B
1:30 p.m.	Florida State Surgical Division, International College of Surgeons, Scientific	Tack Room
1:30 p.m.	Florida Crippled Children's Commission	Cafe Cristal
2:00 p.m.	Florida Medical Association Scientific Section Meeting	Convention Hall
2:00 p.m.	Florida Pediatric Society, Scientific	Card Room
2:00 p.m.	Florida Neurosurgical Society, Business and Scientific	Sky Room Upper
2:00 p.m.	Florida Society of Dermatology, Business	Seminar Room 1
2:00 p.m.	Florida Society of Physical Medicine and Rehabilitation, Business and Scientific	Mezzanine Room 200C
2:00 p.m.	Florida Chapter, American College of Chest Physicians, Scientific	Nassau Room, Country Club
2:00 p.m.	Florida Allergy Society, Scientific	Card Room, Diplomat West
3:00 p.m.	Florida Radiological Society, Business	Mezzanine Theatre
4:00 p.m.	Florida Medical Association Scientific Section Meeting	Convention Hall
4:00 p.m.	Florida Pediatric Society, Business	Card Room
4:00 p.m.	Florida Academy of General Practice, Business	Rumpus Room East
4:30 p.m.	Awarding of Prizes for Exhibit Visitation	Convention Hall
5:00 p.m.	Florida Neurosurgical Society, Social Hour	Sky Room Lower
6:30 p.m.	Florida Society of Ophthalmology and Otolaryngology, Social Hour	Tack Room
6:30 p.m.	Florida Orthopedic Society, Social Hour	Cafe Cristal
6:30 p.m.	Florida Society of Dermatology, Social Hour	Embassy Room
6:30 p.m.	Florida Radiological Society, Social Hour	Mezzanine Theatre
6:30 p.m.	Florida Urological Society, Social Hour	Suite of President, Truett H. Frazier, M.D.
6:30 p.m.	Florida Chapter, American College of Surgeons, Social Hour	Poolside (Alt. Rear Lobby)
7:30 p.m.	Florida Pediatric Society, Social Hour	Card Room
7:30 p.m.	Florida Society of Dermatology, Dinner	Embassy Room

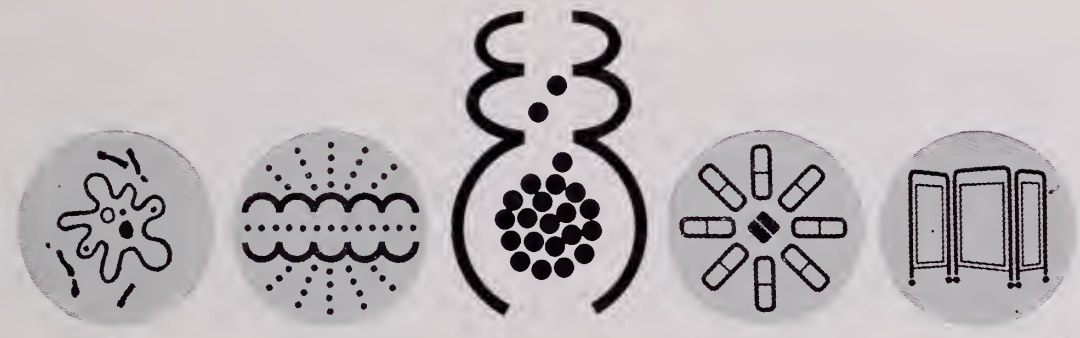
Sunday, May 10

Morning	Registration and Exhibits	Convention Hall
8:00-9:30 a.m.	Delegates' Registration	Corrider Convention Hall
9:30 a.m.	Second House of Delegates Session	Convention Hall
12:00 noon	Dismantling of Exhibits	Convention Hall
1:00 p.m.	Post-Convention Board of Governors Meeting, Luncheon	Embassy Room
	Florida Medical Foundation	Embassy Room

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easy to use: Because 'Miltown' (meprobamate) is compatible with almost any other kind of drug therapy, you'll find it fits in easily with any program of treatment you are now using. It will not, therefore, complicate treatment of patients seen in clinical practice.

Side effects: Slight drowsiness may occur and, rarely, allergic or idiosyncratic reactions, generally developing after 1 to 4 doses of the drug.

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Precautions: Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available in the product package, and to physicians upon request.*

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Supplied: 400 mg. scored tablets, 200 mg. coated tablets.

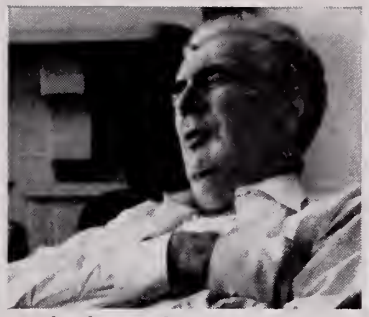
CM-1114



The insomniac



The tense, nervous patient



The heart-disease patient



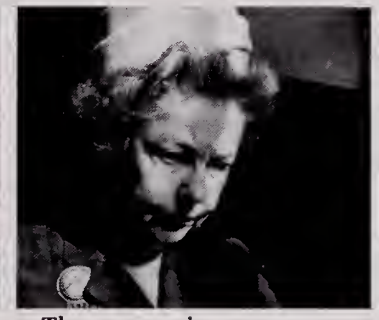
The surgical patient



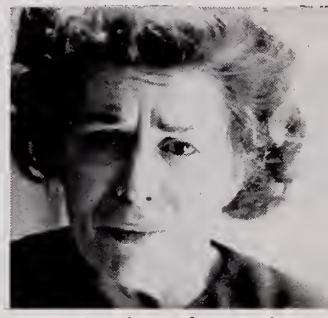
e girl with dermatosis



Tension headache



The woman in menopause



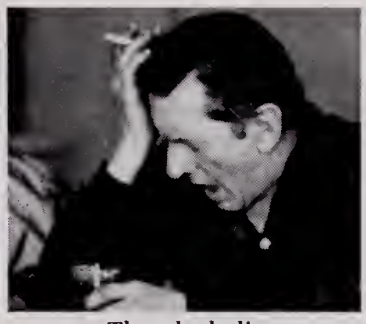
Anxious depression



remenstrual tension



The agitated senile patient



The alcoholic



The problem child

the original brand of
meprobamate

Miltown®



The G.I. patient

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Clinical Comment



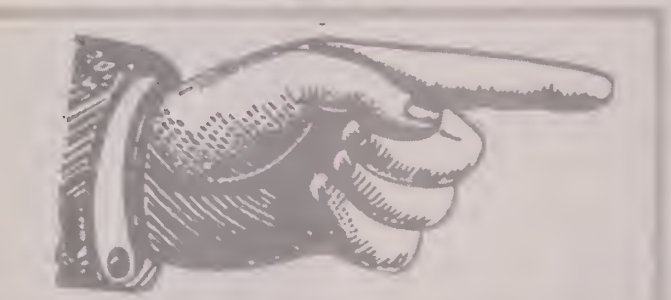
Symposium on Hypertension

On Saturday, January 19, 1963, a symposium on hypertension was held at Mound Park Hospital in St. Petersburg by the Mound Park Hospital Foundation. The panelists were Dr. Arthur C. Corcoran of Cleveland, Dr. Albert A. Brust of Dayton, Ohio, and Dr. Robert L. McMillan of Bowman Gray School of Medicine in Winston-Salem, N. C. Dr. Corcoran described the etiology and pathogenesis of hypertension. He used both a descriptive classification and an etiological classification and discussed genetics, renal, endocrine and neurogenic aspects of the problem. He pointed out that in persons with a diastolic blood pressure of 95 mm. Hg or above, the death rate is twice as great under the age of 60 as in the general population.

Dr. Brust discussed the diagnostic techniques in hypertension and pointed out that because of the advances in the treatment of this disease during the last 10 years, the importance of proper diagnosis has become greater and the problems of the etiology more complex. He stated the purpose of diagnostic techniques in hypertension is to classify the etiology, especially of reversible forms, and to evaluate the severity and rapidity of progression of the disease and to find out target organ damage in order to set goals of therapy. He stressed the importance of the possibility of renal origin in the hypertensive patient of less than 30 years or over 50 years of age. He also pointed out that patients might still have remedial kidney disease (surgical kidney disease) even though they have normal pyelograms. He also discussed the



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four target areas of hypertension, namely, the kidneys, brain, heart and ocular fundi.

Dr. McMillan discussed the treatment of hypertension and expressed the opinion that anyone with a blood pressure of 160/100 mm. Hg should be treated. He stated that at the Bowman Gray School of Medicine a sympathectomy had not been performed in the last 10 years. He pointed out that a California group cured hypertension in a patient with arteriosclerosis obliterans by amputating the effected limb. Placebos, he said, frequently lower blood pressure in patients with so-called neurogenic hypertension, which he thought was different from essential hypertension. He discussed in detail the study he had made with mebutamate alone and in conjunction with reserpine. In the group treated with both drugs, the patient's average blood pressure dropped from 260/150 to 168/90 mm. Hg, and the study had lasted for approximately 20 months. One of the important points brought out in the discussion was that patients receiving reserpine tolerate anesthesia very poorly, frequently go into shock, and have rhythm disturbances including ventricular tachycardia. Elective surgery should not be performed on these patients until the drug has been discontinued for 10 days. If a patient receiving reserpine is subjected to surgery and shock ensues, the treatment of choice is to administer 10 mg. of ephedrine intravenously, and if the blood pressure does not rise in 15 minutes, an additional 5 mg. of ephedrine should be given intravenously. It was mentioned that intramuscular Aramine is of value.

Dr. McMillan pointed out the difficulties in sometimes getting an adequate history on the patients being anesthetized for elective surgery, since over 40 preparations on the market contain reserpine.

In considering all aspects, it was an excellent discussion; however, it would have been better if discussion of treatment had included all hypotensive agents rather than just the two hypotensive agents mentioned. Two specific cases illustrating problems in the treatment of hypertension were presented and discussed at some length.

CHARLES K. DONEGAN, M.D.
ST. PETERSBURG

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The Duval County Medical Society Postgraduate Seminar

The Duval County Medical Society Post Graduate Seminar was held in Jacksonville on September 21 and 22, 1963. There were eight papers presented and two panel discussions. The luncheon and the poolside cocktail party were enjoyed thoroughly by all attending. The outstanding faculty drew doctors from areas throughout north Florida and southern Georgia. Some of the medical highlights follow:

Dr. Frank R. Lock, Professor of Obstetrics and Gynecology, Bowman Gray School of Medicine discussing Endometriosis, said, "this condition is the result of abnormal growth stimuli and not direct implantation." This places endometriosis close to malignant disease in its etiology although there are only 12 cases in the literature where it appears that endometriosis is directly related to cancer. Dr. Lock stated that there is a 40% expectancy for child bearing after conservative surgery for endometriosis and that there definitely is a place for progestational agents in the treatment. When hysterectomy is required in a young person conservative resection of the ovaries should be considered as hormone substitution therapy leaves much to be desired.

Dr. Howard Fabing, Chief of Neurology and Psychiatry at Christ Hospital, Cincinnati, Ohio, addressed the Post-Graduate Seminar on the topic of The Hallucinagenic Drugs. Dr. Fabing traced the history of these drugs both in modern medicine, folk lore and primative rituals and related the findings of current investigation to the possible etiology of schizophrenia. Dr. Fabing described how he had experimentally administered LSD to the author, Aldous Huxley, who subsequently wrote "The Doors of Perception" and "Heaven and Hell," which were based on his experiences while under the influence of these agents. In these works Mr. Huxley laid particular emphasis on the intensification of color which he described as Kaleidoscopic. Dr. Fabing concluded by raising the question, Is schizophrenia a disease of metabolic origin which may arise due to perversion of action of naturally occurring substances or their breakdown products?

James R. Jude, M.D. of Johns-Hopkins who is internationally known for his work on external cardiac massage spoke on resuscitation. All physicians should be prepared to administer to a person with cardiopulmonary arrest. Success in the treatment of resuscitation depends on immediate and proper diagnosis. The head should be lowered immediately, neck extended and mouth to mouth or mouth to nose aeration of the lungs should be undertaken. Effective ventilation is indicated by movement of the chest. External cardiac massage, by depressing the lower third of the sternum, can then be applied. One should shout for help but should not leave the patient. When available, drugs are important, especially adrenalin. There is no doubt that adequate circulation can be maintained for long periods and this method should be continued while the patient is transported to a hospital. When evidence of damage to the central nervous system is present or cardiac death is evident, resuscitation should be discontinued.

William Dameshek, M.D., Director, Blood Research Laboratory, New England Center Hospital, discussing "Systemic Lupus" emphasized the fact that this is a disease of auto-immunologic disturbances; that there is a gradual piling up of immunologic abnormalities manifested in a positive serology, arthritic changes, idiopathic thrombocytopenic purpura, skin changes, renal involvement, and the L. E. cell phenomenom. Mention was made of the use of cytotoxic drugs in systemic lupus based on the assumption that interference with immunologic mechanisms brought about by such drugs (eg. 6-mercaptopurine), should be beneficial.

Dr. Rocco A. Calandruccio, attending orthopedic surgeon from the Campbell Orthopedic Clinic in Memphis, Tennessee, and chief orthopedic surgeon at La Bonnehour Children's Hospital conducted orthopedic grand rounds for the JHEP orthopedic residents at Duval Medical Center on Saturday morning, September 21, 1963. He described his original research (which is in progress) on circulation of the femoral head in fractures of the neck of the femur.

In his presentation to the Seminar group on Sunday morning, he described the important physical diagnostic aspects of many frequently encountered orthopedic conditions which are ordinarily not covered in medical school training and the standard physical diagnosis text books. He illustrated his presentation with a beautiful series of original slides and photographs.

Lieutenant Colonel Eddy D. Palmer, Chief of the Medical Service, Brooke Army Hospital, discussed, authoritatively, the vigorous diagnostic approaches to upper gastrointestinal hemorrhage, pointing out that this approach (emergency supportive care while ice water lavage of the stomach is being done, is followed in rapid succession by endoscopic examination and x-ray studies). This does not appreciably enhance the hemorrhage already under way, and results in a higher diagnostic accuracy than is otherwise possible. Mortality rates have not been affected.

Taking part in the panel discussion on vitamins, Dr. Palmer presented Vitamin K intoxication as a cause for jaundice in infants, and the use of vitamins in the treatment of problems in malabsorption.

We would like to thank the following doctors for their help in compiling the above—Drs. Ed Sullivan, Ted Batchelder, Sam Root, Charles Mead and Roy Hancock.

James P. McNeil Jr., M.D.
Jacksonville

Reprinted from Duval County Medical Society Bulletin November 1963.

Others Are Saying

Freedom—An American Heritage

Among the freedoms, the freedom of choice is the one most dear to the American Medical Doctor. Against all threats, real or potential, the physician and his professional organization rally in defense. Because of this vigilence and the aid of other Americans, the right of freedom of choice has been successfully defended over and over.

One must answer the following questions. Is this freedom being shackled in Pinellas County? Is freedom of choice being denied Americans in Pinellas County where we justifiably take pride in our conservatism and prosperity? Are there those among us who vocally support this freedom yet resent a little soul searching?

Objections have been raised concerning medical care rendered by contract physicians in some of our non-profit church affiliated retirement homes. Yet on occasion the charges made for visits to these homes by the physician of choice has been so high that the patient could not afford his services. Therefore the freedom of choice was lost for economic reasons.

Our system of caring for service patients in our hospitals and the inability of some patients to call on the private practitioner because of economics, gives us another group of Americans who have lost their freedom of choice. The Pinellas County Negro and even the Negro physicians often do not enjoy this freedom. In the area called the "true south," physicians have long cared for all regardless of race or ability to pay. Perhaps the waiting facilities were separate but the remainder was equal. In Pinellas County the Negro patient must use a Negro doctor or one of the small percentage of physicians who are willing to render them care. Ofttime the Negro physician is refused his right of freedom of choice in consultants and required to utilize the physician assigned to the service patients as a consultant for his private patients.

If we in American Medicine wish to remain free we must carry the standard of freedom for all. We are not free to refuse service without adequate justification from those seeking our individual aid. Can we expect to remain free if a single American can point his finger at us saying, "You have denied me my freedom of choice."

ELC

Reprinted from Pinellas County Medical Society Picomeso Mail Bag, January 1964

Meetings

April

"Pediatrics—The Sick Child in General Practice," April 9-11, Auditorium of Mound Park Hospital, St. Petersburg.

May

Ninetieth Annual Meeting, Florida Medical Association, May 7-10, Diplomat Hotel, Hollywood-by-the-Sea.

June

American Medical Association, June 21-25, San Francisco, California

ANNUAL MEETING GOLF TOURNAMENT

Play will be from noon Saturday, May 9 at the Presidential Country Club. Many prizes including Duval County Medical Society Trophy and The Orlando Loving Cup. Prizes awarded on basis of gross score, net scores and the Calloway system. Contact Harry M. Permesly, M.D., 750 S. Federal Highway, Hollywood. Phone 922-4686.

CLASSIFIED

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20¢ for each additional word.

WANTED: Pediatrician, ENT, Internist and Dermatologist for new medical building ready Feb. 15. Adjacent to hospital in beautiful location on Gulf of Mexico. Fine practice opportunity. Write 69-510, P.O. Box 2411, Jacksonville, Fla.

WANTED: Pediatrician for association with two obstetricians. Office space, basic equipment and guaranteed income are available for an acceptable man. Write 69-551, P.O. Box 2411, Jacksonville, Fla.

OFFICE SPACE FOR RENT: Medical suite, approximately 600 sq. ft. in separate consultation. two treatment and laboratory rooms. Share secretary and reception room. New professional building, excellent furnishings. Suitable for specialty or general practice. Clarence H. Schilt, M.D., 2161 McGregor Bldg., Ft. Myers, Fla.

WANTED: General Practitioner for Clinic-Hospital. Salary open—plus bonus. Write 69-535, P.O Box 2411, Jacksonville, Fla

GENERAL SURGICAL RESIDENT: Board eligible July 1964. Florida license, with broad training background, multilingual, seeks partnership with established surgeon, preferably in Dade County. Particulars, references, photo supplied on request. Write 69-569, P.O. Box 2411, Jacksonville, Fla.

PEDIATRICIAN to associate in small group, including another pediatrician with large practice. Progressive, guaranteed salary, plus bonus. Write 69-570, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER for association with group in Cape Kennedy area. Thriving potential, guaranteed salary, plus bonus. Write 69-571, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER WANTED: Join actively growing General Practice, Dade County, Florida. Salary $18,000 first year; $24,000 second year; partnership third year. No investment needed. Resume to 69-561, P.O. Box 2411, Jacksonville, Fla.

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OBSTETRICIAN - GYNECOLOGIST WANTED: To associate with two man group. Large established practice in Miami; Board eligible or certified; prefer under age 35. Write P.O. Box 384, Miami Shores, Fla.

PRACTICE FOR SALE: Profitable, well established urban family practice in south Gulf coast area. Outstanding opportunity to take over. Office building, fully equipped. Will finance. Leaving for residency July 1. Write 69-566, P.O. Box 2411, Jacksonville, Fla.

SURGEON, former Associate Professor at leading Postgraduate Medical School, desires to purchase going practice: partnership or group. East or Central Florida. Write 69-582, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER WANTED for county supported medical clinic. Major duties involve general diagnostic screening and treatment. 40 hour week; two weeks vacation; two weeks sick leave; social security, and group insurance benefits. Please send resume and any request for more information to: Occupant, P.O. Box 772, Main Post Office, Orlando, Fla.

IMMEDIATE OPENING for Florida licensed Anesthesiologist. Working with well established group. Contact Dade County Medical Association, 2 Coral Way, Miami. FR 1-2601.

PEDIATRICIAN WANTED: To take over active growing practice in East Coast town. Leaving for association in metropolitan area. Unusual opportunity. Write 69-573, P.O. Box, Jacksonville, Fla.

GENERAL SURGEON: Board certified, former Fellow in Surgery at The Lahey Clinic. White, male, aged 47, seeking location in Southeast Florida. Family reasons. Seeking association with established specialist or group. Write 69-575, P.O. Box 2411, Jacksonville, Fla.

MEDICAL OFFICE AVAILABLE: Vacated by enlarging partnership. Centrally located. Adequate for two men. T. J. Kaminski, M.D., 1010 Hickory St., Melbourne, Fla.

WANTED: Florida licensed Anesthesiologist. Opening in near future with well established group. Write to Business Manager, P.O. Box 1877, Hollywood, Fla.

GENERAL SURGEON with established practice moving family to Florida. Desires association with qualified surgeon or group. White, age 53, Southerner. Harvard M.D. Diplomate. Good health and character. Experienced. Florida license. Write 69-568, P.O. Box 2411, Jacksonville, Fla.

INTERNIST WANTED: In Cape Kennedy area for association with small group. Guaranteed monthly salary, plus participating bonus and congenial associates. Write 69-572, P.O. Box 2411, Jacksonville, Fla.

NURSE ANESTHETIST: 40 hour week, no night calls except rare occasion, salary open. Contact Memorial Hospital, Hollywood, Florida.

AMERICAN BOARD RADIOLOGIST, diagnosis and therapy wants clinic or small hospital, preferably in the Florida Keys. Have Florida license. Available for interview. Write 69-584, P.O. Box 2411, Jacksonville, Fla.

PATHOLOGIST: Completing third year approved Pathology residency. Florida license. American born and graduated. Desires position as assistant or associate. Write 69-585, P.O. Box 2411, Jacksonville, Fla.

WANTED: Permanent part time employment medical transcription after June 1 in Tampa-St. Petersburg area. Seven years experience. Your office or my home. Reasonable rates. Write 69-586, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER: Desiring relocation on Southeast Coast would like to share office space with established surgeon or specialist on a rental basis. Write 69-579, P.O. Box 2411, Jacksonville, Fla.

FOR SALE: Practice and equipment in residential area of favorite East Coast city. Exceptional opportunity for versatile physician. Present practitioner leaving for specialty training when new man is established. Facilities include fully equipped lab used by other phsyicians. Owner now works 5 half days weekly with excellent return. Write 69-591, P.O. Box 2411, Jacksonville, Fla.

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LOCUM TENENS: Wanted for June, July and August. Salary open. Must have Florida license. General Practice with some obstetrics. Air-conditioned office. Could lead to permanent association if mutually agreeable. Write 69-592, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER needed to take over active practice in growing Gulf Coast town. Present physician returning for further study. Fully equipped office and laboratory. Write 69-577, P.O. Box 2411, Jacksonville, Fla.

LOCATION DESIRED: Physician completing residency July 1, 1964 in Obstetrics-Gynecology. Military service completed. Desires association or information of area needing Ob-Gyn. man. Write 69-594, P.O. Box 2411, Jacksonville, Fla.

SURGICAL RESIDENT desires pre-ceptor arrangement on or about Jan. 1965. Complete Gp II program. Florida born and educated. Florida license. Preferable long-lasting associateship later. Execllent references. Write 69-595, P.O. Box 2411, Jacksonville, Fla.

OBSTETRICIAN - GYNECOLOGIST: Board certified wishes South Florida location in association with an individual or group. White, male, age 49, experienced, licensed. Write 69-588, P.O. Box 2411, Jacksonville, Fla.

WANTED: In Virginia, excellent General Practitioner opportunity with early partnership, then ownership. Virginia license required. Thriving practice. Fully equipped. Dr. Willard Smith, Hampton, Virginia.

OPHTHALMOLOGIST: Age 31, married, Board eligible. University trained; wants association with individual or group. Florida license, available August 1964. Write 69-589, P.O. Box 2411, Jacksonville, Fla.

GENERAL SURGEON needed in Haiti for month of April to operate at the Albert Schweitzer Hospital. Board, room and lodging will be furnished to a surgeon and his wife if she desires to accompany him. Any qualified general surgeon interested please contact Richard E. Strain, M.D., 401 Miracle Mile, Coral Gables, Florida 33134.

WANTED: General Practitioner to associate with General Surgeon in Central Florida. Fully equipped office including complete laboratory and X-ray facilities. Write 69-590, P.O. Box 2411, Jacksonville, Fla.

FOR SALE: Westinghouse X-ray machine, 50 milliamp, tilt table. Good condition. Reasonable. Write William R. Earnhart, M.D., 1004 E. Atlantic, Delray Beach, Fla. or call 278-3222.

OFFICE FOR SALE: Well-equipped, very reasonable, on Southeast coast. Excellent opportunity to take over. Leaving to specialize. Write 2411 Broadway, Riviera Beach, Fla.

OBSTETRICIAN-GYNECOLOGIST: Age 33, married, completing approved residency July 1, 1964 at large metropolitan hospital in New York City. Florida license. Seeks association for eventual partnership in Florida. Write 69-587, P.O. Box 2411, Jacksonville, Fla.

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The Florida Medical Association offers placement assistance through the Physician Placement Service, P.O. Box 2411, Jacksonville 3. This service is for the use of physicians seeking locations, as well as physicians seeking associates.

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Woman's Auxiliary

Woman's Auxiliary Convention 1964

Mrs. Abbott Y. Wilcox, Jr. (Peggy) of St. Petersburg, President of the Woman's Auxiliary to the Florida Medical Association has announced plans for the Auxiliary's Annual Convention on May 7, 8 and 9 at the Diplomat Hotel in Hollywood, Florida. The Palm Beach County Medical Auxiliary will hostess the convention.

On Thursday, May 7, the State Auxiliary officers and County presidents will have a pre-convention Board Meetings in the Mezzanine Theatre of the Diplomat Hotel at 2:00 p.m.

On May 8 the House of Delegates will meet at 9 a.m. in the Mezzanine Theatre. The convention theme will be, "Where Did your Missile Soar?" in keeping with Mrs. Wilcox's yearly theme of "New Auxiliary Horizons." Besides transacting convention business, each Auxiliary President will report on her county's most outstanding accomplishment of the year which will be illustrated by styrofoam missiles and will be used as centerpieces for the tables at the luncheon following the meeting at 12:30 p.m. in the Les Ambassadeurs Room of the Hotel.

Edward R. Annis, M.D., President of the AMA will be guest speaker. Guest tickets for doctors will be $3.00 on sale at Auxiliary table in Lobby, Registration Desk or at door of dining room.

The Florida Medical Association has made available to Auxiliary members a Hospitality Room, which is Room 200A situated just off the mezzanine floor to the right of the elevators open for use during the convention for Auxiliary members and guests.

The new state officers will be installed at the close of the House of Delegates meeting by Mrs. William H. Evans, President-Elect of the Woman's Auxiliary to the American Medical Association.

A membership meeting will be held in the suite of the President on May 8th following the luncheon. On Saturday, May 9th, a post-convention Board meeting and School of Instruction will be held in the Nassau Room of the Diplomat Country Club. A shuttle service will provide transportation from the Hotel to the Country Club.

Mrs. Lloyd J. Netto
Convention Chairman

International Health Activities Committee Woman's Auxiliary to the Florida Medical Association, Inc.

International Health Activities, barely two years old, is the infant committee of Medical Auxiliaries across the country. I.H.A.'s aim is to bring medical relief to a worldwide community and also to extend to foreign doctors and their families a welcoming hand. It is the express wish of the American Medical Association that the Auxiliaries undertake a plan in which we can offer hospitality and assistance to the more than 15,000 foreign doctors on our soil. Many program chairmen have asked these doctors to speak at their meetings. One Auxiliary has established a "loan closet" from which the foreign families can borrow items ranging from sofas to toasters. Another group has provided English classes for our foreign visitors at their county medical building. We have been urged to do anything and everything to promote the good will of your foreign colleagues. We have been encouraged to join forces with agencies such as World Medical Relief, Inc., and Direct Relief Foundation. These two groups are prepared to accept sample drugs, (excluding narcotics), used surgical instruments (from used thermometers to used X-ray equipment), and bandages made from old sheets. Both of these "outlet agencies" meet all legal requirements for handling drugs and are regularly examined by FDA inspectors. However, that is the extent of involvement by any government either here or abroad. Help is sent where it is needed—it is sent free of charge—it is sent to the needy, regardless of color or creed.

We understand that there is a project of the World Medical Association called "Doctor to Doctor" whereby you can send journals abroad on a person-to-person basis. In conjunction with this, we, your "other halves" would like to send any of your medical texts (less than four years old) to the Darien Book and Aid Plan.

All contributions such as instruments, texts, periodicals, and shipping costs are deductible for tax purposes as a "contribution in kind to the U.S. Committee of World Medical Association."

This is a new project with us—and we need your help. For it is to *you* the drugs come—*you*

have the texts and periodicals—*you* have the used instruments and equipment. We have the information as to what is needed—where and how to ship it—but most important, we have eager hearts and willing hands. You'll be hearing from us soon. Our baby, I.H.A. is born—the booster shots have come from the A.M.A. and our National Officers—the food must come from you, the Florida Medical Association.

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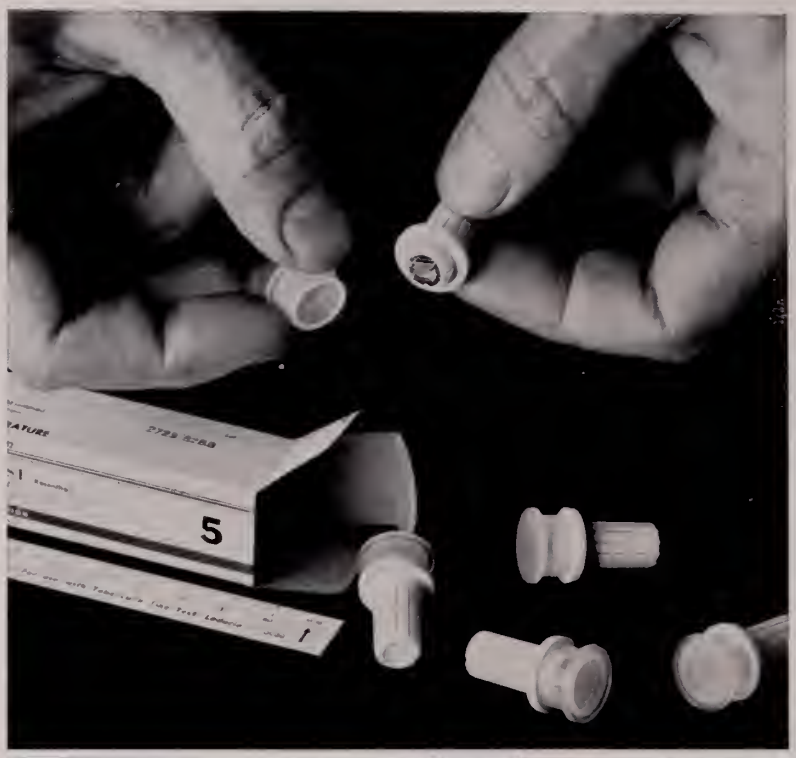
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[1] Simon, F. & Bernstein A.: "The Treatment of Obesity in Patients with Cardiovascular Disease," Angiology, *12*:32-37, Jan. 1961.
[2] Plotz, M.: Modern Management of Obesity, J.A.M.A. *170*:1513-1515 (July 25) 1959.
[3] Bernstein, A. & Simon, F.: "Treatment of Obese Diabetics and Arteriosclerotics," Clin. Med. 907-920, May 1961.



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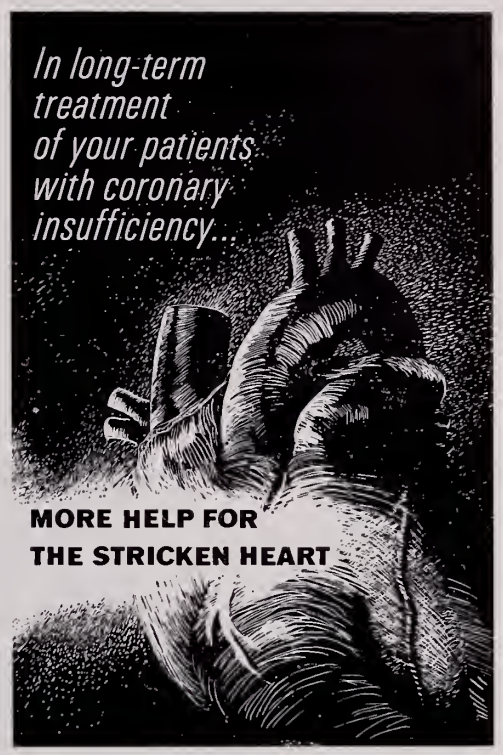
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Precautions: In elderly or debilitated patients, it is important to limit the dosage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, to be increased gradually as needed and tolerated). As is true of all CNS-acting drugs, until the correct maintenance dosage is established, patients receiving Valium (diazepam) should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving an automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam)—particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

Since Valium (diazepam) has a central nervous system depressant effect, patients should be advised against the simultaneous ingestion of alcohol and other central nervous system depressant drugs during Valium (diazepam) therapy. Safe use of Valium (diazepam) during pregnancy has not been established. The usual precautions are indicated when Valium (diazepam) is used in the treatment of anxiety states where there is any evidence of impending depression; particularly the recognition that suicidal tendencies may be present and protective measures may be necessary. The usual precautions in treating patients with impaired renal or hepatic function should be observed.

Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (*e.g.*, convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

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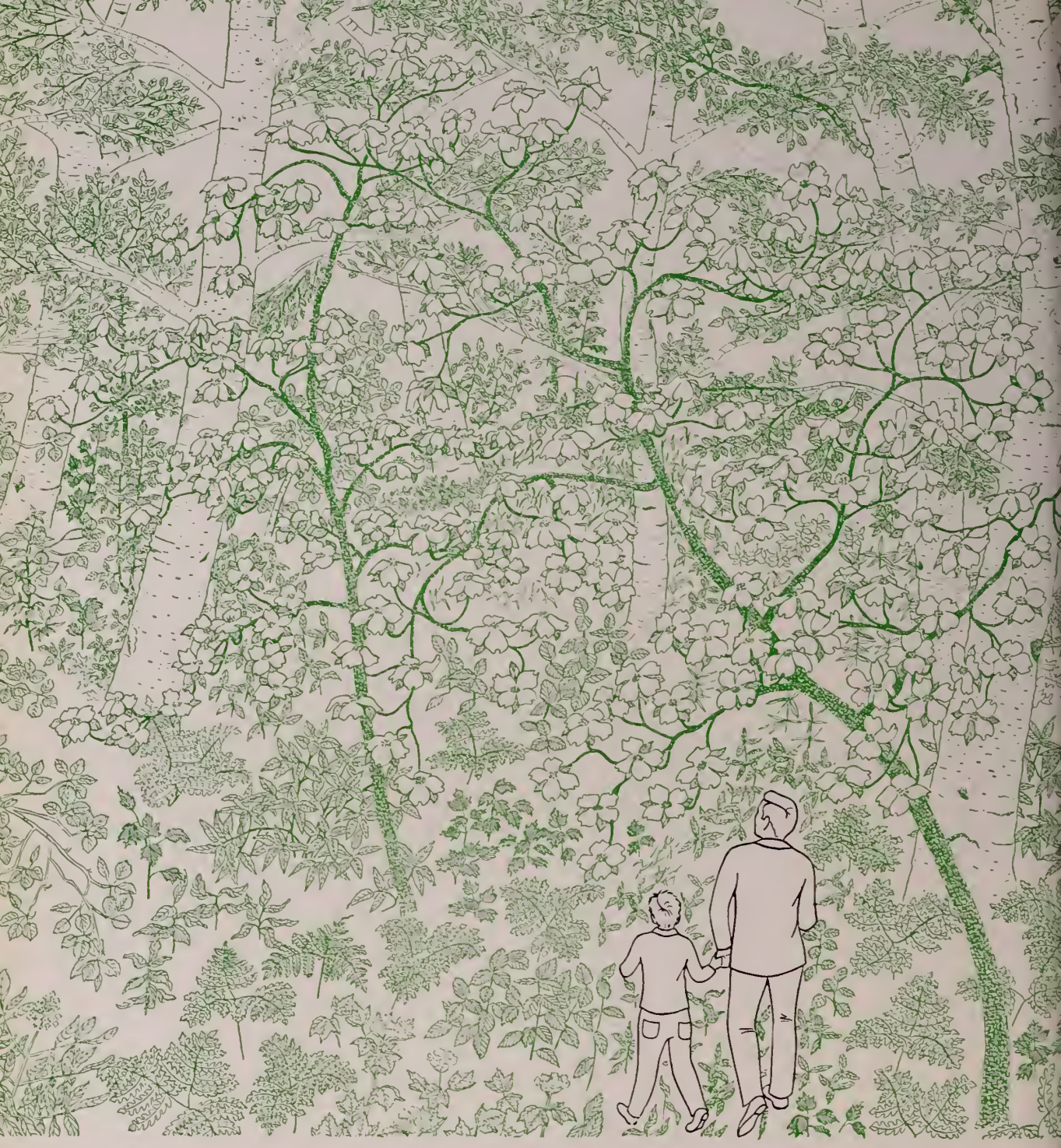
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The JOURNAL of the Florida Medical Association

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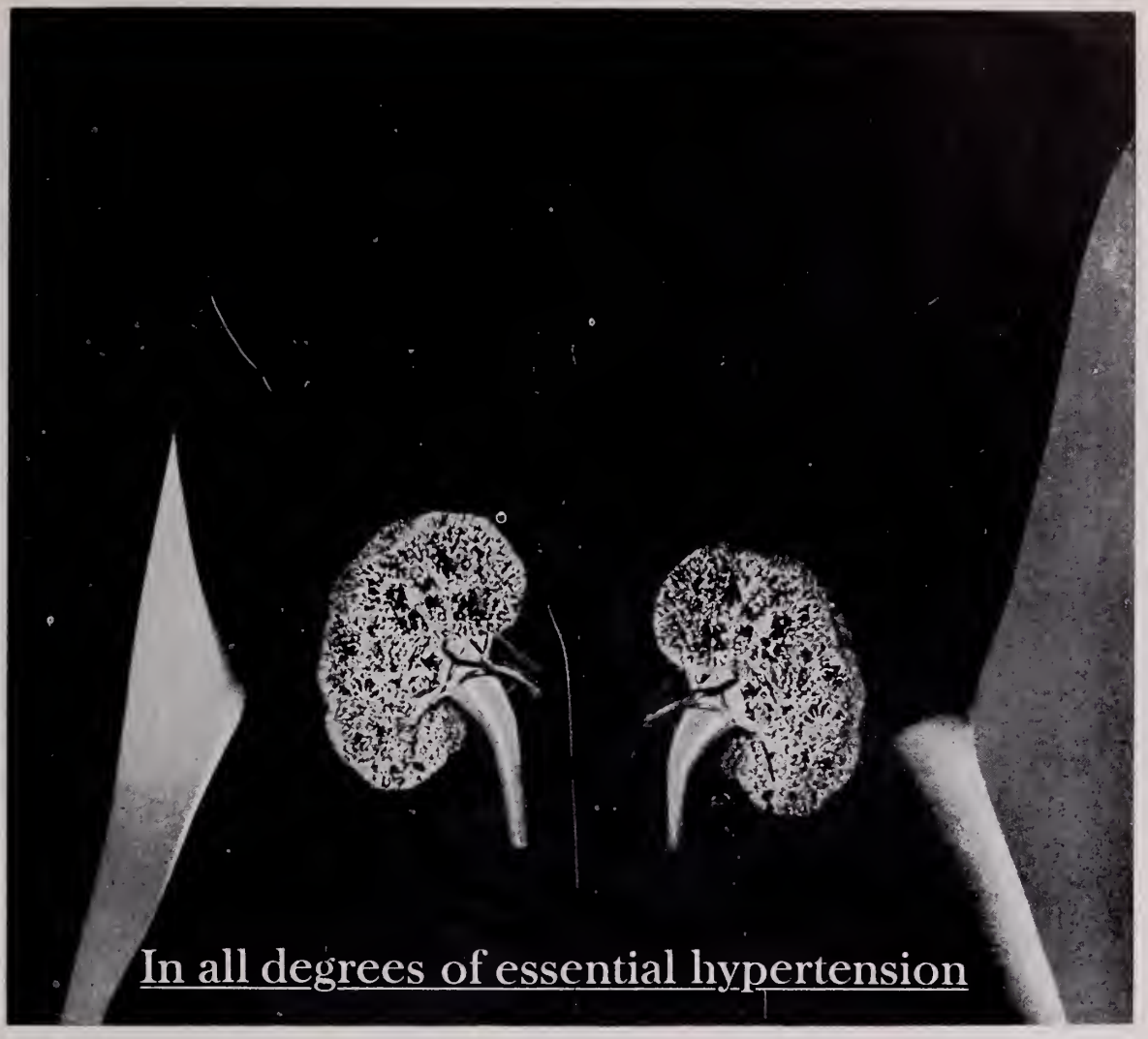
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References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

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Volume 51, Number 5, May 1964

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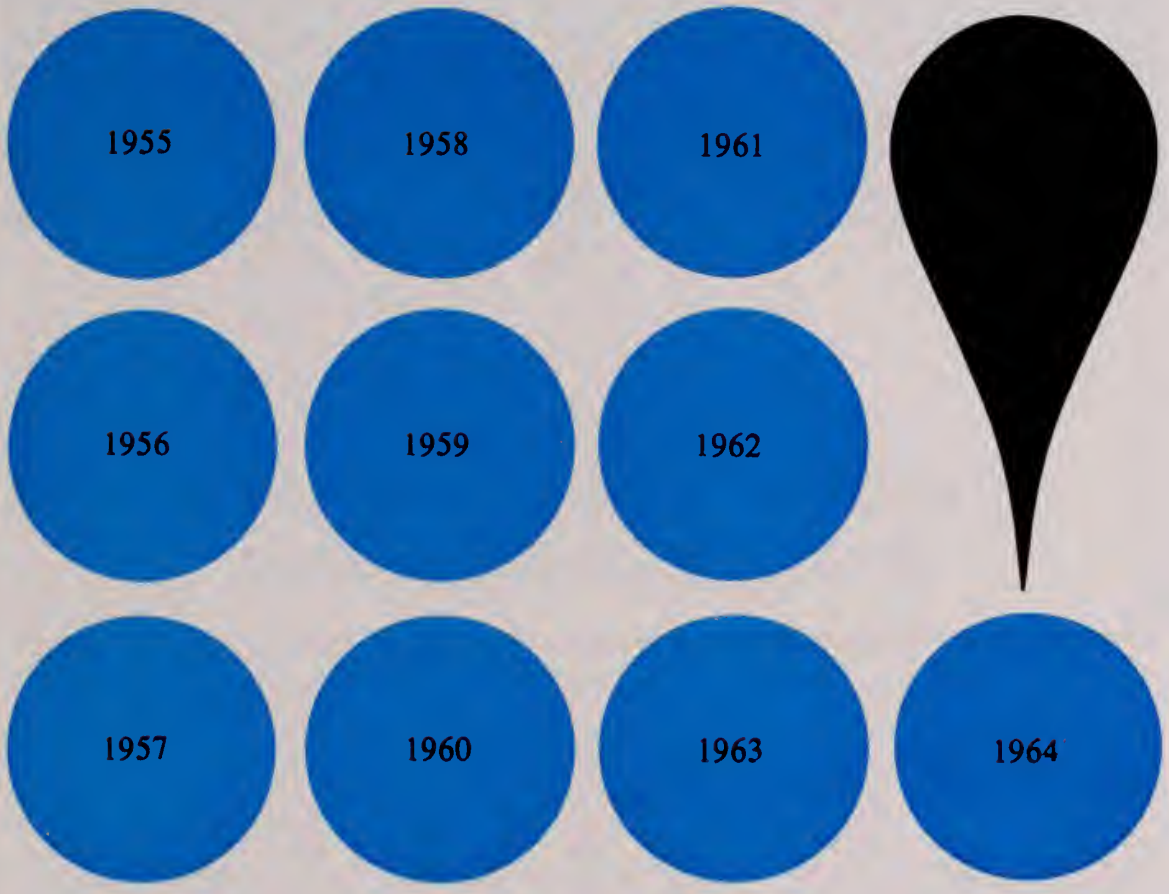
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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

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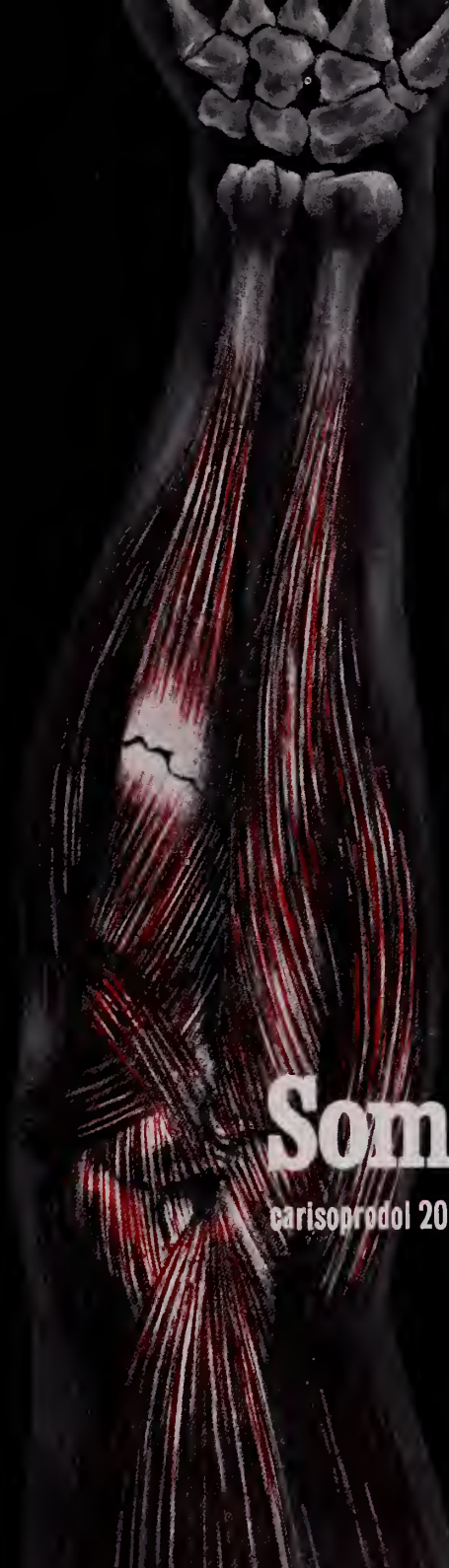
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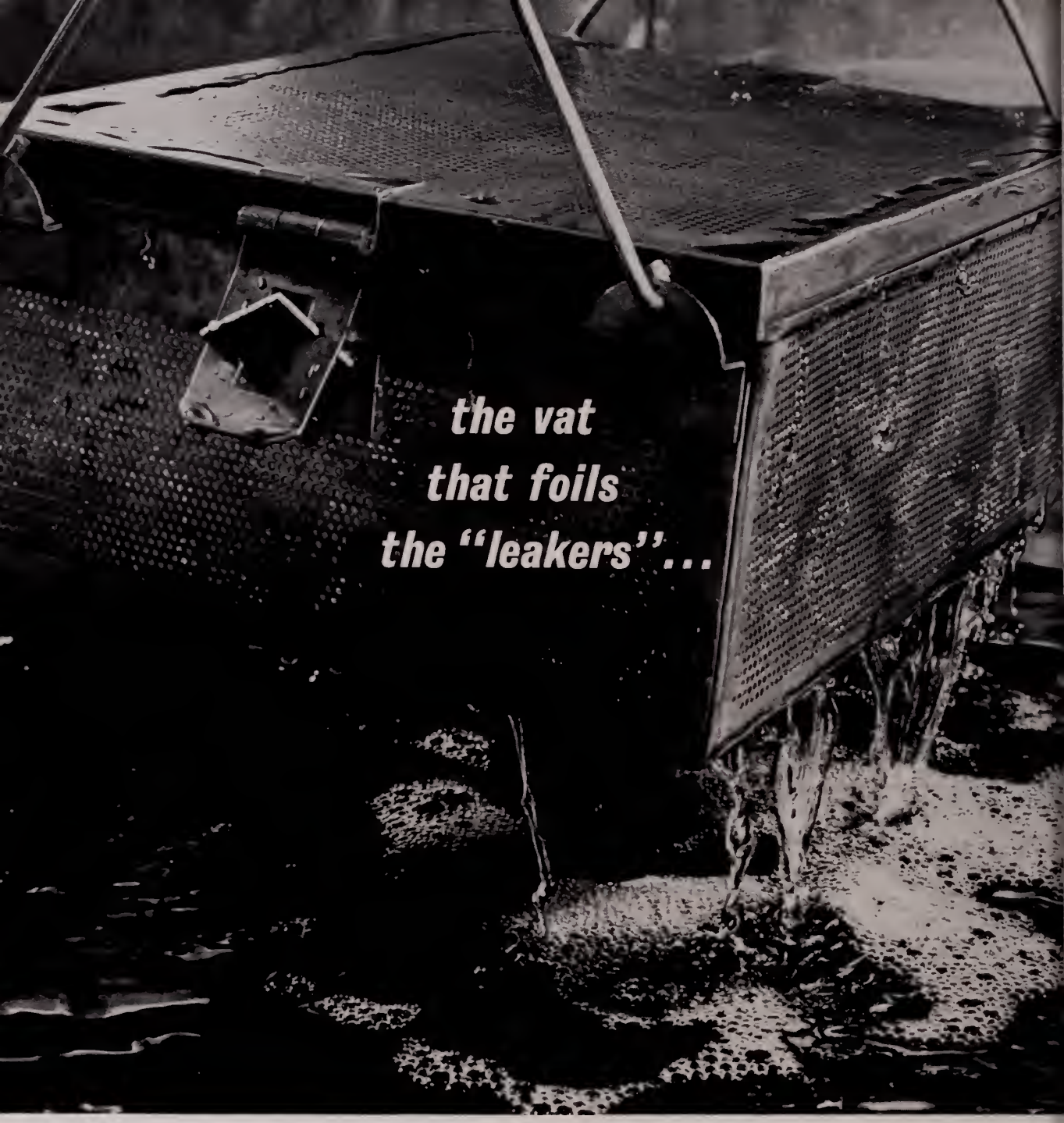
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The JOURNAL
of the Florida Medical Association

Through the years the Florida Medical Association has enjoyed a close relationship with the Florida State Board of Health. A mutual understanding of their respective problems has resulted, and a cooperative effort directed toward a solution of these problems has frequently proved successful. To further an awareness of current and anticipated problems which will require a continuing cooperative effort between the Association and the Board of Health, this issue of The Journal of the Florida Medical Association is devoted to a series of essays prepared under the direction of Wilson T. Sowder, M.D., State Health Officer. Miss Elizabeth Reed, Director, Division of Health Education, Florida State Board of Health, kindly served as guest editor. The Journal is pleased to present this renewed approach to the concerted effort of the two groups to insure a healthy and happy future for the state.

T.M.

Foreword

When you consider the diversity of public health problems revealed in the following papers, you can see we have come a long way since the reason for the establishment of a state health department was the control of communicable disease. These articles, which cover a broad spectrum, are only a sample of the intriguing problems which present themselves today to public health authorities. Consider the subjects covered: occupational health, nutrition, family planning, suicide, mental retardation, health education, radiation, arthropods, chronic diseases, wastes, rabies, laboratory services. We could have submitted others on tuberculosis, food poisoning, polio, hospitalization of the indigent, nursing homes, shell fish, research, encephalitis, fluoridation, home nursing care—to name only a few of the approximately 100 responsibilities (prescribed by law) of the Florida State Board of Health and the 67 county health departments.

A public health problem might be defined as one which affects the health and well-being of a sizable segment of the population. Add to this the public's realm of greatest interest—health—and the reason for the urgency of many public health problems as exemplified by state legislature action and voluntary groups concern is easily seen.

The increasing trend toward specialization of the private practitioner has been accompanied by a broadening of interests in public health. The pattern of illness today is changing from the acute and specifically caused disease to the more chronic, ill-defined troubles based upon a host of interrelated causes not always in the domain of medicine.

What will the future bring? No crystal ball need be polished to see the need for increasing involvement in the behavioral sciences. The private physician is concerned today not only with the relief of the immediate complaint of the patient, but also in achieving emotional as well as physical adjustment to his environment. He will, therefore, need to collaborate with psychologists, psychiatric social workers, public health nurses, mental health workers—among a host of other health-related personnel.

In the early days of official health work in Florida, a health department staff consisted of physicians, nurses, sanitarians and clerks. Today such diversified personnel as veterinarians, ecologists, microbiologists, dentists and health educators may also be found.

Life expectancy at birth is increasing steadily, bringing with it social and public health implications. Care of the aged and the importance of the chronic diseases have emerged as problems of tremendous depth. Coupled with these is the realization of the part that rehabilitation can play in making more productive the latter years of our citizens. We have barely envisioned the potential of the mentally retarded, the magnitude of fetal loss or the waste of human lives in custodial mental institutions.

Why a state health department? Because there needs to be an agency in the state where official and voluntary agencies and lay and professional persons can come together for a discussion of common health problems. Such an agency acts as an intelligence center for predicting health problems, preventing disease, promoting health

and taking control measures that will insure the continued good health of all our people in Florida, including those from the rest of the country who continue to pour over our borders.

The State Board of Health is presently directed by a policy-making Board and a number of advisory committees and commissions. Almost all of these include private practitioners of medicine. We need the help of practicing physicians in our perennial dilemma of a coordinated approach to common problems. For in the final analysis, the healers of the sick must also be the protectors of the well.

Wilson T. Sowder, M.D.
State Health Officer

The Obligation to Teach as Well as to Treat

What short cuts can be taken by the busy practitioner to educate his patients—to give them the information he thinks they should have? With increased caseloads spurred by mass media's crash "medical education" programs for lay persons and the desire of the general population to reach "high-level wellness," the average practitioner is aware of this educational problem, but cannot always take the time to meet his patients' needs.

Many persons are grossly misinformed. With great reluctance they yield cherished points of view on health matters, only after a person for whom they have great respect (often a physician) corrects them. But today a physician has less time and more patients, a paradox which plagues him.

The problems of an aging population and the increasing number of persons with chronic diseases also make health education increasingly important because the latter can only be controlled through the action of the informed persons themselves. Many patients are discontented because doctors do not tell them enough about their condition. The modern patient is eager to receive medical information. If he does not get it from medical authorities, he will get it from sources often not authoritative or even reliable.

The hospital has been displaced in the public's view as the focal point in the attack on disease. The physician's office has come more into prominence. But as the literacy rate goes up and the patient desires more information than the busy doctor has time to give, will his office (as a source of education) be displaced by mass media (often slanting the facts), or centers of health information, as has been suggested by some authorities?

An educational service by prescription may hold one of the answers. Presumably a physician would describe briefly what he wanted the patient to know, then send him to some nearby center where a qualified health educator would use a variety of methods to inform: audiovisual aids, brochures, conversation, group meetings.

Programmed instruction is causing quite a stir in the educational world. On a trial basis now is programming for the instruction of diabetic patients. An oversimplified explanation is that a machine presents information and then gives a test which the patient takes by pressing appropriate buttons. If an incorrect answer is given, he must go over the material again before he can proceed.

If the busy doctor does not have time to talk at length to his patients in the hospital, has he considered the possibility of initiating closed circuit television programs within the institution? General information has been successfully given on baby care, diet instruction for diabetics, ways of living for heart patients, emphasis on rehabilitation for stroke patients. This medium has also been used to point out the contribution of the various departments in the hospital in helping the patient to get well. These programs should inform the patient as well as engross the relatives who frequently are in greater need of understanding and support than the patient. Doctors

and nurses can be taught to operate the telecasting equipment.

And speaking of relatives, they might be interested in touring a hospital health museum. The second in the country was recently installed in a Reading, Pennsylvania, hospital. Twenty-five exhibits have been set up. The stated purpose is to help patients and their families by giving a better understanding of illnesses and treatment and of what they can do to hasten recovery.

If the doctor is a participant in any public health clinics, he will learn to advise and depend upon public health nurses, particularly in their work in maternal and well child clinics. Frequently a series of classes is set up which amplifies the doctor's teaching. If 30 patients attend the clinic, while 15 are being seen by the physician, the other 15 are seeing a motion picture, watching a demonstration or discussing common problems under the leadership of a public health nurse or health educator.

Some physicians or their office nurses hold classes one night a week in their offices for selected patients. Antepartum patients and their husbands are a natural for this kind of teaching, especially effective in natural childbirth.

A careful consideration of the reading matter provided for the patients in his office should be a responsibility of the physician. Most of Florida's county health departments are glad to supply the doctor's office with many different attractive brochures; some drug and insurance firms will provide excellent pamphlets devoid of advertising.

People are much more sophisticated about health matters than they used to be. Research has shown that doctors generally underrate patients in assessing what health knowledge they have and tend to be too elementary in their explanation. And we are passing from a medicine in which you do something to a patient into medicine in which we must do something with the patient and in which he must do much more on his own.

The busy physician can save time and gain friends (as well as educate) if he will begin where his patients are—that is, sit and listen for a few moments to what information or misinformation the patient has—and carry on from there.

Looks as if we are heading toward a 35 hour day!

Elizabeth Reed
Health Education

Microcosms, Molecules and Gadgets

"Encephalitis virus, fluorescent microscope, autoanalyzer"—research curiosities of 10 years ago—are becoming integral parts of the public health laboratory program of today.

In the field of clinical chemistry, automated instruments have provided the capacity for performing large volumes of highly reproducible tests with a tremendous saving of time and effort. Such equipment, used effectively in diabetes and heart disease control programs, will undoubtedly be applied to the early detection of these and other chronic diseases once the yardsticks for their measurement have been defined by the research scientist. Probably the greatest potential use of these "mass-production" instruments will be realized in the so-called "multiphasic screening programs" of the future in which "health profiles" of population groups will be obtained from an analysis of appropriate clinical and laboratory screening tests. Cases uncovered by these procedures will be referred to private physicians for further study in private laboratories.

Instrumentation has further broadened the scope of the public health chemist who must provide laboratory support to physicians and agencies charged with the responsibility of enforcing medicolegal statutes and regulations. In order to meet these needs he is equipped to perform such complex procedures as toxicological examinations, drug and narcotic identification, and blood alcohol analyses. Similarly the laboratory has "tooled-up" to cope with new problems associated with surveillance of the environment for industrial and radiological pollutants. It is important to note that the latter program has also served to establish a civil defense capability for detecting chemical and radiological warfare agents in the event of a national emergency.

The public health microbiologist, faced with the related problem of providing the means for

prompt identification of biological warfare agents, is also concerned with the development of more rapid and accurate methods for use in the routine diagnostic laboratory. Perhaps the most promising tool which has been devised for this purpose is the fluorescent microscope. Employing fluorescein-labeled specific antibody or antigen it is possible with this instrument to identify quickly microorganisms in pathologic tissues or in cultures and to detect humoral antibodies as well. In the public health laboratories of Florida, these procedures are being used in the diagnosis of rabies, streptococcal disease, syphilis, gonorrhea and toxoplasmosis. As research in this area progresses, it should be possible to implement the laboratory of the future with a "battery" of such reagents sufficient to meet the needs of routine as well as emergency situations.

It should be mentioned that automated test procedures have appeared in the bacteriology laboratory as well. Food products may be rapidly screened for "additives" by means of a simplified disk-plate method employing Bacillus subtilis as a test organism. A variation of this technique has been successfully applied to the detection of phenylketonuria in infants. The latter appears to be a forerunner of tests designed to detect inborn errors of metabolism associated with mental retardation.

In the field of virology, a significant breakthrough occurred when it was found that the polioviruses could be readily propagated in cell cultures derived from human or animal tissues. Subsequent widespread use of the tissue culture method for virus isolation has led to the discovery of a host of previously unknown agents including the ECHO and adenoviruses. The combination of this versatile technique with serological procedures such as the complement-fixation, hemagglutination, and serum neutralization tests has made it practical to offer the private practitioner a relatively comprehensive viral diagnostic service.

Following the 1962 epidemic of St. Louis encephalitis in the Tampa Bay area, virological laboratory facilities were expanded to support an investigation of the causative factors of that outbreak. These efforts, which are being concentrated in the four county area where the epidemic occurred, are being supplemented by a statewide encephalitis surveillance program as well. The focal points of these investigations are the reporting of human cases by the practicing physician and the laboratory identification of the causative virus from appropriately collected specimens. This information, when correlated with data obtained on the distribution of these viruses in nature, should point the way to prevention of future outbreaks.

These developments typify the effect of some of the dramatic technical advances taking place in our times. Paradoxically, the future activities of the public health laboratory may well be related to problems created by the mechanized world of tomorrow.

Warren R. Hoffert
Laboratory

Where Do Your Patients Work?

As we travel Florida's highways, we note that our state is undergoing a change of face. Everywhere we see construction and progress. New highways are being built, new homes are under construction, business and industrial establishments are being erected at a rapid pace. With these changes come a variety of problems. Many of these problems have serious health implications. Highway traffic is delayed or detoured; the resulting impatience and frustration lead to accident and injury. Some homes are erected without proper attention being given to those details of construction that help assure the safety and well-being of the homemaker. Business and industrial establishments moving into new quarters find themselves beset with numerous scheduling and getting-settled problems; with normal routines and behavior patterns disturbed, the probability of injury due to accident is enhanced. Land formerly used for agriculture or scrub oaks in Florida is being converted to use by the multitude of industries supporting the space program. Areas once relying heavily on tourism for income are actively seeking electronics, plastics, plating, smelting, air conditioning and other types of industries. Each of these types of industries brings

with it a potential for environmental health hazards. These may be extramural, as in the case of air or stream pollution; or intramural, such as the hazards of occupational diseases associated with exposure to chemicals (metal fumes, solvent vapors and others) or physical agents (extremes of temperature or humidity, excessive noise and others). The alert private physician will do well to inquire closely into the occupation of his patient, particularly in puzzling cases, and to consult his county health officer as to the health problems presented by a particular occupation.

The Florida Development Commission has reported Florida became the ninth most populous state in the union in 1961. On July 1 of that year Florida's population was estimated at 5,222,000, and it is estimated that the population will reach 8,000,000 by 1970. About 50 per cent of Florida's population is in the employable age group, 19 to 64 years; and about 75 per cent is classified as urban. Nearly 4,000,000 live in those counties below the southern boundaries of St. Johns, Putnam, Alachua and Levy counties. The sheer impact of the coming of the space age to Florida is emphasized in the following figures comparing population figures for Brevard County with those for the whole state.

Year	Brevard County	Florida
1940	16,000	1,897,000
1950	23,600	2,771,000
1960	111,400	4,952,000

In the past 15 years, advances in technology have decreased the relative importance of some occupational diseases, have had little effect on some, and have increased the relative importance of others. Citrus dermatitis from sectionizing fruit is relatively rare today because of the low demand for canned fruit sections following the advent of the fresh frozen product. Other problems have shown little change in relative importance, having grown with the state. Among these are: lead exposures of smelting and battery plant operators, solvent exposures of degreasing or dry cleaning operators, dust exposure of foundry, cement or stone-cutting workers, and exposures to soaps and other cleaning compounds of restaurant workers.

In recent years, we have encountered several instances where the changes accompanying progress have resulted in the conversion of a potential occupational health hazard into a very real occupational health problem. For example, a small, well established business, after being located in one place for many years, found it economical to move to new quarters, to install new equipment and to add air conditioning (primarily for employee comfort). In the old plant, before prosperity set in, windows were kept open almost all year round and fans were operated as necessary for comfort cooling, so that vapors of airborne contaminants such as solvents and cleaning fluids seldom built up to hazardous concentrations. In the tightly buttoned-up, completely air-conditioned new plant, however, where air was recirculated for economy of operation of the air-conditioning system, concentrations of contaminants reached hazardous levels. Usually, we have found that the simple expedient of providing make-up air to the system prevents concentrations from building up to dangerous levels.

There is some evidence that extremely dry air, such as that encountered in homes heated in the winter with hot air and to a lesser extent in residences or businesses which are air-conditioned in the summertime, can lead to respiratory distress in some persons.

The establishment of each new industry, though cause for rejoicing as the state's coffers are replenished, must also be regarded as a possible breeding ground for new occupational health hazards.

H. Grady Callison
Radiological and
Occupational Health

SPEED UP REGISTRATION
HAVE YOUR BADGE STAMPED BY MACHINE
BRING YOUR PLASTIC MEMBERSHIP CARD TO
THE ANNUAL MEETING, MAY 7-10, HOLLYWOOD

Food Facts

They Are Not Simple Any More

When you prescribe a diet for your patient, when you yourself go out to eat in a restaurant, when your family sits down to a meal at home 10 or 15 years from now, can you be sure just what is in the foods eaten and what the effect will be on the individual? Will he be oversupplied with some nutrients, undersupplied with others and, in addition, have a generous sprinkling of additives other than nutrients?

Have you been keeping up with the growing accumulation of data on food additives? What about our increasing use of food supplements? Do you keep abreast of the research on what used to be the simple foodstuffs—fat, protein, carbohydrate? Is "overnutrition" just a term, or does it really have meaning for the next generation and the next? Nutrition has been implicated as etiologic in a variety of chronic diseases in which the threat appears to be overnutrition rather than undernutrition.

These and many other questions come to mind when we begin to consider nutrition in the future. Not very long ago, we were content to discuss nutrition in terms of a balanced diet, the basic four food groups, three good meals a day and similar phrases. Today, we are more cognizant of the inter-relationship of nutrients, of timing in relation to kinds of food eaten, of metabolic differences in response to food eaten, of adapting food to metabolic deficiencies, of inborn errors of metabolism, of the psychologic implications of food. We are also aware of the rapid changes in food processing and the strides in food technology with even more accomplishments to come in the near future. To select food intelligently, we must know more about it and teach our patients more about it.

If we are continually extending man's life, then is it not our responsibility to find ways and means of increasing man's active, productive years and to make those years enjoyable ones insofar as good health can do so?

Today in Florida, we see a goodly number of people celebrating their eightieth, eighty-fifth and ninetieth birthdays, but we also see far too many who have little cause to celebrate such events though chronologically they have reached that time. These numbers are going to multiply in the years ahead and it is up to us to set the signal lights for the direction in which we want to go. Diet is one of the important factors which we need to consider in relation to longevity and health. Studies suggest the significance of poor nutrition in early years to degenerative disorders which mark the onset of senescence. Long time dietary patterns may affect enzyme systems which undoubtedly are closely related to the aging process.

Many of the chronic diseases have a distinct dietary component and as our scientific knowledge increases in respect to this component, we must translate such knowledge into everyday foods and meals for the lay public. This is, indeed, an area where a little knowledge is a dangerous thing, for have you ever seen anyone who did not have something to say about his beliefs and ideas on diet? And, of course, most of this comes from popular magazines, television and newspapers plus a goodly assortment of food quacks. Why? Because doctors and other professional personnel have been "too busy" to take time to interpret the situation correctly and in simple terminology. Would you not be confused, too, if all you had to rely on were the popular sales talks on unsaturated fats? The issue is confused enough, scientifically speaking.

The area of diet and nutrition has been left to take care of itself too long and we have seen some of the consequences in both health and money. Billions of dollars are wasted on food fads and quackery. We can only guess at the extent of injury to the health of the nation.

The physician, who makes up diet lists for his patients and who must laboriously explain why it is important that they be followed, will have to be prepared to answer the intelligent questions fired at him by today's inquiring public. The information is available—if he wishes to use it.

Mary Brice Deaver
Nutrition

Wastes-Wastes-Wastes!

As Florida grows, so do her public health problems. Multiply the number of people and you multiply health conditions which occur as the result of proximity—and disposal of all types of wastes, human and industrial. These in turn lead to the knotty problems of municipal wastes, air and stream pollution, and industrial wastes.

The biggest headache is that of municipal wastes. In Florida, the major advances in the collection and adequate treatment of these products has taken place since the close of World War II. This period also corresponds to the most rapid growth of population of the state and to the change from a rural state to one which is predominantly urban.

The early concept of sewage disposal was based upon the ability of nature to assimilate organic matter and make it inoffensive. This concept utilized water, but this is no longer acceptable because our waterways can assimilate just so much waste. Also recreational and other uses of water have increased fantastically in recent years.

Florida used to be known as the septic tank state, but as people moved closer and closer together, and particularly when they moved into communities on a lot-by-lot basis, it became necessary to provide sanitary sewerage systems. But with much of the new housing being constructed beyond existing city limits, it was not always politically or economically acceptable to extend this service to the developing area. Today many builders begin their planning with consideration of a pure water supply and a satisfactory sewerage system, but still approximately one third of Florida's people live in areas where there is no system or an inadequate one.

There must be expansion of existing systems to meet Florida's growing needs, as well as the building of new facilities. In order to bring this about it may be necessary to have countywide water and sewer authorities, particularly in the more densely populated areas. The treatment of municipal wastes must have the highest priority if our water resources are to be conserved and protected. Every physician and public health authority lives in dread of the possibility of outbreaks of water-borne diseases.

We beg and cajole industries into putting down roots in Florida—only to discover that industrial wastes may make us wish we had looked the gift horse in the mouth. The characteristics of these wastes are so varied that one can say that the only thing you will find in common is their variation.

Where do these wastes come from? About 70 per cent of the supply of phosphate in the United States is found in a 500 square mile area in Polk County. The citrus industry of Florida constitutes 80 per cent of the national total. In 1959 Florida produced more wood pulp than any other state. These figures please us until we remember that the three mentioned, out of thousands of smaller industries, produce considerable amounts of waste waters.

Some wastes are quite poisonous to man and beast. Electroplating produces wastes of such characteristics. Cyanide, in various forms, is an excellent material for plating solutions. Unfortunately, it is also deadly to man, animals and marine life.

Methods can be introduced which can greatly lessen the amount and strength of almost any industrial wastes which are released. But in most instances these methods will be costly with little return—except protection of the public's health. Only occasionally is a by-product evolved that helps pay for the cost of waste treatment. Cow-feed from citrus pulp is one example.

Many industries like to locate on waterways and in Florida; the larger communities have also been located there. The early Spanish explorers, whose favorite mode of travel was ships, sailed into our bays and up our rivers and established colonies and towns. Wherever there has been a body of water, man has immediately thought of its use for the disposal of wastes. In this vein, Florida with its rapid growth of population and industry immediately following World War II saw its waterways become grossly polluted.

Stream pollution was once related primarily to domestic wastes, but now we are concerned with pollutants which are difficult to identify and whose long term effects have not yet been determined. Sometimes we know how to reduce the strength of organic pollutants; in some instances, we even know how to neutralize or eliminate chemical pollutants. It is difficult, however, to keep pace with the variety and complexity of the products of modern day chemistry.

Another major factor is the need for clean waters to satisfy the opportunities for fishermen, boating enthusiasts, swimmers and just plain everyday people who desire to live near the water.

The backbreaking job is to persuade people and industries to spend vast sums of money for benefits that are not easily visualized. A tax-paying public can see highways, sidewalks and street lights, but the installation of a system of pipes underground or a sewage treatment plant hidden in the woods does not impress people.

Prodding city or county officials to undertake a program involving a bond issue or other means of raising revenue is not easy. Every citizen must feel he has a stake in the matter and the more articulate and influential must be heard in support. Physicians are first among these. Many today are serving on city councils or citizens committees and can lend their voice in support.

In talking about wastes, we cannot stop without mentioning another that has a tremendous potential for damage both to man and his environment—air pollution. It is true that much of the evidence concerning long term effects of air pollutants is circumstantial; yet incriminating evidence continues to mount. It has been demonstrated that rural dwellers are less likely to have lung cancer, bronchitis and respiratory diseases than those who live in urban areas. At infrequent intervals dramatic disasters call our attention to this hazard. The names of Donora, Pennsylvania, Meuse Valley, Belgium, and London, England, bring to mind the many who died and the many more who became ill. These resulted from unfavorable topography, bad weather conditions and high concentrations of air pollutants.

Air pollution can destroy vegetation and is said to be harmful to cattle. The villain is sometimes smelter gases. Here in Florida fluorides and sulfur oxides have been responsible. But what about the long term effects of low concentrations, as well as the more dramatic cases? Areas that are affected may vary from time to time due to wind directions and velocity. This variation makes the solution of the problem much more difficult.

We may say that air is free—but is it? We must emphasize to the industries within our gates that we need and want them, but they, too, must bear the responsibility for keeping our communities desirable, healthy places in which to live.

What does the foregoing add up to? Concentrations of people and industries produce wastes—potential hazards to health if they are not recognized early, or better yet, prevented before they become dangerous. Health departments in Florida need the cooperation of private physicians who will be among the first to recognize this threat.

David B. Lee
Sanitary Engineering

New Vistas For The Mentally Retarded

"Mentally retarded"—what bleak associations these two words bring. Dreary corridors, insensitive attendants, children who are "put away," adults who are never mentioned by their families. Common associations all, and even today frequently too apt. But as in so many other hopeless areas, the exciting new biology of medicine is bringing changes not only from year to year but from month to month in our basic concepts. Many of the advances in general medicine, while not aimed specifically at preventing mental retardation but rather at preserving life, have happily proved to function in this fashion as "side effects." Consider, for example, the prevention of kernicterus with its severe and permanent mental sequelae by the prompt and judicious use of exchange transfusions in the erythroblastotic infant. Or speculate upon how many patients with bacterial meningitis vigorously treated with antibiotics have escaped the deficits of intellect which so often occurred in survivors before these drugs were available.

A real impetus has come with the elucidation of the defects in the so-called "molecular diseases"—the understanding of the role of enzymatic deficiencies in such metabolic diseases as phenylketonuria, galactosemia and others which has made treatment by means of diet substitutions possible. Chromosomal studies have shed much light on the subject of mongolism and have shown a distinction between familial and nonfamilial types, making possible realistic family counseling as to the risks to future children. Hope ran high for a time that some type of cell manipulation might even bring chromosomal disorders under the control of man. Impossible as it seems now, we have but to recall the other fancies and impossibilities which are now accepted as commonplace.

But there are counterbalancing factors. Better medical treatment, paradoxical though it may seem, is contributing in some ways to an increased number of defectives in the population. The salvage rate of premature infants, and other babies with obstetrical complications resulting in brain damage, is much higher than formerly and unfortunately the prognosis for mental development, especially for prematures, is now shown not to be as hopeful as we once thought. Treatment of the metabolic diseases, such as phenylketonuria, controls only the symptoms and does not affect the basic abnormality. It follows that persons who once would have been segregated in institutions because of gross mental incompetency will now be capable of normal lives, reproducing and adding to the genetic pool in society. Carrier rates necessarily will rise steeply. Already as a result of more extensive casefinding, we are having to revise upward our estimates of incidence.

Services in our mental hospitals, unlike our tuberculosis hospitals, must be expanded rather than decreased. It is an obvious cliché to say that we need more institutions, more and better trained personnel. There is nothing new in the concept, although it is part of the new order of change, that we need smaller, cottage-type institutions, halfway houses, shops and equipment for rehabilitation (or perhaps it would be more accurate to call it "habilitation") services. The planning for satellite treatment centers, clustered around our central institutions, is a forward move. Development of special classes for retarded children either as part of public school systems or as projects of voluntary groups at the community level is coming to be regarded as a necessity by local citizens.

It is certain that the more and better the services offered, the greater will be the demand from our citizens who want to take advantage of them. The dollars and cents cost for all these services is great. Clearly, the more money we can spend for the retarded, the more elaborate our facilities can be. But money so spent is money that cannot be spent for something else. Much as we wish to meet these obligations, we must be realistic. If such a disproportionate amount is spent that it results in the curtailment of educational opportunities for unusually bright children or other needed health services for normal persons, it is certainly not prudent. We must be compassionate on one hand, but on the other hand realistic and tough-minded if we are to strike the proper balance. It is here that the civic-minded physician can make a great contribution. By virtue of his specialized knowledge and position in the community, he can help to keep the problem and its potential solutions in balance.

It would seem, therefore, that the most productive money we could spend would be that aimed at keeping people out of our institutions. All our exciting new medical discoveries will be the more gratifying if we can put them to the greatest possible use. Already they point out a number of measures we must adopt.

We must have basic diagnostic centers available. It is no longer sufficient merely to describe a patient as "retarded." We must know, insofar as it can be determined, how retarded he is, why he is retarded and what is his potential achievement level. Misdiagnosed patients must not be placed in our institutions, labeled as mentally retarded, when actually they may be victims of psychic, emotional or sensory disorders.

We must plan for adequate casefinding, encouraging the use of simple screening tests for metabolic diseases, such as urine testing for phenylketonuria (PKU) in physicians' offices and public health clinics. Such tests for infants are a legal requirement in some states.

We must be prepared to offer genetic counseling on a realistic and scientific basis. This involves the training of personnel in the understanding of biochemical genetic disease. It necessitates the study of families of the retarded, as well as the patients themselves.

We must take a more realistic attitude toward sterilization and under the right circumstances accept it as a sensible tool.

We must maintain central registries of patients with long term and metabolic diseases. We will be disappointed if we expect sudden gains from these, but they can be invaluable as sources of information for geneticists in the future. Epidemiological patterns may emerge and, in any case, valuable genetic data will be collected which may prove of greatest value to future generations. Fanciful as it seems now, it may well be that the newborn infant of the future will be routinely subjected to a battery of metabolic and genetic studies which will predict much of his future medical history.

We must improve our education concerning mental retardation in the medical schools. Young physicians must be prepared to evaluate mental-

ly retarded patients and must be able to judge rationally which patients should be institutionalized and which will benefit from the stimulation of home care. Parents must not be urged hastily to institutionalize young infants to spare themselves future pain, but must be guided to offer their retarded offspring the benefit of a loving home life when appropriate and to accept professional aid when needed.

Finally, we must strengthen our facilities for prenatal care, particularly in the lower socioeconomic groups, in an effort to cut down the high incidence of prematurity with its adverse effect on developmental potential.

Marilynn Miles
Maternal and
Child Health

Radiation Problems

In less than three generations, one use of one type of radiation source has become so important that it currently produces a population exposure one third of the recommended limit. This limit specifies that the average per capita genetic dose to the population to age 30 should not exceed 13 rems (a unit of radiation dose). This radiation use which has grown so is that of x-ray diagnosis in the healing arts; its current contribution approximately equals that which the human race has always received from natural background radiation. At the present time, fallout, the operation of nuclear reactors, the industrial and research uses of radiation sources and the medical use of radioisotopes contribute less than 1 per cent of the limit. The sum of all these exposures leaves, at the present time, approximately one third of the recommended population exposure limit as a reserve within which the benefits of nuclear energy can be reaped without paying an unacceptable biological price.

Exposure incident to diagnostic x-ray use frequently can be reduced without affecting the quality of the examination. One of the major continuing programs of the State Board of Health is the consultation with users of x-ray machines to assist them in reduction of exposures to themselves, their patients and the public. A statewide coverage of dental offices is nearly complete and coverage of other x-ray offices has extended to about one half of the state. The physician himself can participate in assuring that the benefit derived from proper x-ray diagnosis outweighs any radiation risk by using protective equipment and procedures and discretion in x-ray use.

Radioactive materials are assuming increasing importance as a source of radiation exposure. In a unique shift of governmental authority, the U.S. Atomic Energy Commission is transferring to the various states much of its regulatory activity involving radioactive materials. Six states have entered into agreements for such a transfer. The State Board of Health is making the preparations to assume this program. Notwithstanding any regulatory program, the key to limiting radiation exposure is in the proper handling and confinement of radioactive material at the point of use by medical and other users.

Radioactive materials may escape the control of the user and enter the environment (fallout or release of radioactive waste). The State Board of Health has set up a substantial program of surveillance of radioactivity in air, precipitation, water, milk and other environmental materials. The physician, too, may be involved in this subject in the future. He may be questioned about the significance of the existing situation. He may have to understand and explain such things as the reduction of radioactive materials in food items by allowing decay of short-lived radioactivity before releasing them for consumption. When proposals are made for reducing the uptake of radioactivity, it will be necessary to evaluate and advise on the medical consequences of such measures. For example, the elimination of milk from the diet as a measure to reduce strontium-90 uptake may in fact have serious nutritional consequences, may reduce calcium intake to the extent that strontium-90 intake is increased or may result in the seeking of calcium from sources bearing an even higher level of strontium-90.

The expanding exploitation of radiation sources presents new potential health problems. The physician is affected for he must make good use of his own radiation sources and assist in the evaluation of any problem and its possible solutions so that he may both assist his patient and reassure the public.

Charles E. Roessler
Radiological and
Occupational Health

Answering Cries For Help

Suicide is a major killer. Each year approximately 20,000 people in the United States take their own lives. For most of the past half century suicide has ranked among the first 10 causes of death of adults in this country.

In Florida, suicide was reported as the cause of death of 713 persons during 1962. Although this figure is probably considerably lower than the actual number of suicides committed, suicide nevertheless ranked as the tenth leading cause of death. White males had the highest suicide rate and, among white males of all ages, suicide ranked as the eighth leading cause of death; in the 15-35 age group it ranked second, and in the 35-44 age group, fourth.

Despite the extent and seriousness of the problem, to date little research has been done on the subject and few systematic efforts made to prevent suicides. To a considerable extent this is a result of the attitudes which members of the health professions hold regarding suicide. In many instances our attitudes are based primarily on the folklore and popular beliefs held by the general public. There is increasing evidence that many of these beliefs are false. The following review of the facts[1] should be kept in mind by every practitioner of medicine:

Suicide threats and attempts must be taken seriously. Of any 10 people who kill themselves, eight have given definite warnings of their suicidal intentions. This finding contradicts the frequently held belief that "people who talk about suicide don't commit suicide."

It is not true that suicide happens without warning. Studies reveal that the suicidal person gives many clues and warnings regarding his suicidal intentions. Alertness to suicidal symptoms may prevent suicidal behavior.

Most suicidal persons are undecided about living or dying, and they "gamble with death" leaving it to others to save them. Almost no one commits suicide without letting others know how he is feeling. These distress signals can be used to save lives.

A person who is suicidal is not suicidal forever. Fortunately, individuals who wish to kill themselves are "suicidal" only for a limited period of time. If they are saved from self destruction, they can go on to lead useful lives.

Suicide does not run in families. It is an individual matter and can be prevented.

Suicide occurs in all levels of society. It is not limited to the rich or poor.

All suicidal persons are not mentally ill. Studies of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy, he is not necessarily mentally ill. His overpowering unhappiness may result from a temporary emotional upset, a long and painful illness, or a complete loss of hope. It is circular reasoning to say that "suicide is an insane act," and therefore, all suicidal persons are psychotic.

Suicides usually occur during or following severe emotional crises. Often suicidal persons have undergone a number of such crises or have been emotionally disturbed for an extended period of time. During such crises many of them seek help from their physician, minister or friends. Some talk about their suicidal thoughts and impulses. Others do not discuss such feelings, but talk rather freely about their conflict and worries. Many are even vague about these and attempt to deny or minimize the crises they are experiencing. It should be recognized, however, that each in his own way is begging for help. The prevention of suicide lies in our ability to recognize the severity of their problems and our willingness to answer their cries for help.

Numerous studies have shown that the family physician is one of the first sources to which many persons turn for help when they or a member of their family experiences a severe emotional disturbance. For this reason, it is essential for the physician to be as sensitive to the emotional problems of his patients as he is to their physical health. Often a suicide occurs which might have been prevented if someone had been able to recognize certain clues in the victim's behavior shortly before his death. Getting affairs in order, making a will, discussing insurance policies and similar activities are warning signals of possible suicide if these actions are accompanied by suicidal talk or action and general unhappiness.

[1] Some Facts About Suicide, U. S. Department of Health, Education, and Welfare, Public Health Service, U. S. Government Printing Office. This booklet was written by Drs. Edwin S. Shneidman and Norman L. Faberow, Co-directors of the Suicide Prevention Center in Los Angeles, California.

The key to prevention of suicide is alertness in all patient contacts and diagnostic evaluations. The maxim, which contends that unless the professional thinks about a particular entity he is unlikely to recognize it, applies equally to the accurate detection of suicidal tendencies in disturbed patients. At the same time the professional must cultivate and hold a mature attitude about suicide. Taking lightly the suicidal talk and threats of persons in our care indicates immaturity in professional attitude. Suicide is a major cause of death and warrants the full respect of the mature diagnostician and therapist. We cannot joke with the disturbed and depressed patient who may be contemplating suicide. If the extent of his depression is recognized and the severity of his conflicts understood, the physician is in a position to help the patient himself or to refer him to another professional who can do so. The need to answer his cry for help is urgent.

Travis Northcutt
Mental Health

These Women, Too, Are Our Concern

Following the precedent of private medical practice, the Florida State Board of Health encourages the provision of child-spacing services as a part of sound maternity care. It is thought that this service, not unlike many others provided by health departments, should be offered where such is medically, socially and economically indicated.

During 1961 and 1962, some 45,000 women were provided maternity services from Florida county health departments. It is not unreasonable to suspect that many of these patients were among the caseloads for both years and are to be found again among the 1963 caseload. It is generally known that public health maternity patients are found among the least privileged economic groups in our society. Some public health workers have commented that "chronic pregnancy" seems to be one of the chief characteristics of this group.

"These women just don't care how many babies they have" reflects opinions not uncommon to discussions concerning the frequency with which pregnancy occurs among public health maternity patients. According to a 1962 study conducted by the Bureau of Maternal and Child Health of the State Board of Health, a "what's the use" attitude may be more akin to stereotype than to fact. The study undertook to describe public health maternity patients and to determine whether or not these patients expressed desires to bear additional children. Two thousand six hundred and twenty-three maternity patients (who attended county health department clinics) were interviewed by public health nurses in 29 Florida counties. In brief is a summary of findings: (1) nearly two thirds of the patients receiving maternity services in the study area were Negro; (2) nearly three fourths of the respondents were reportedly married; (3) more than 80 per cent of the respondents have one or more living children; (4) the respondent group reported having a total of 7,099 living children; (5) more than 70 per cent reported not wanting to have any more children; (6) among the respondents who reported wanting additional children, more than 90 per cent expressed a desire to wait two or more years before having another baby.

Are they not concerned? "I can't take care of the ones I got now—I don't need no more!" Remarks to this effect are not uncommon among this group.

The provision of child-spacing services through public health facilities is by no means without precedent. Nearly three decades past, North Carolina provided such services to public health maternity patients; more than 100 Georgia counties offer birth control services; in Florida, 44 county health departments offer these services to public health maternity patients.

Though the provision of child-spacing services through public health facilities represents no recent nor radical innovation, there is growing interest in and awareness of the propriety of making services available to women who are not normally found in the mainstream of private medical care.

Physicians interested in child-spacing services will find like interest among many county health officers who welcome advice, assistance and cooperation from the practitioners of private medicine.

L. L. Parks
Maternal and
Child Health

Zoning, Planning and Arthropods

Florida in the past has given little thought and consideration to proper zoning and planning for a safe and healthful environment in which people are to live adjacent to compacted areas. Certain basic prerequisites must be taken into consideration in the creation of a long range environment where the great masses of the population are to reside. In fact, people are no exception; they are, for the most part, like all other animals in that they seek those areas where food is available, climatological conditions are favorable, and employment can be found. Farming and business interests have led the way in developing areas, and professions and tradesmen have followed along to sell their wares. The general population is placed in those expedient areas by the governing powers of a community without consideration for hurricanes, floods, contaminated air and water, and the arthropod vectors of human diseases.

In modern society it would appear that all phases of government and all business and professional interests should join forces in requiring that all human dwellings in subdivisions designed for construction in high water table areas have storm sewers with proper outlets and paved streets with gutters. It is past time for the state to stop and think and meditate and profit by the mistakes of the past. The storm clouds will come again, bringing drenching sheets of rain and wind tides to inundate and destroy vast amounts of property now built along the low coastlines and flatwoods river bottoms.

The last chapter has not been written as far as human arthropod-borne diseases are concerned; in fact, the first chapter has not been written, as far as encephalitides are concerned. It has been my prediction for many years that one day one of these virus diseases would reach epidemic proportions. That day came in 1962 when 199 human cases of St. Louis encephalitis were reported in the Tampa Bay area.

In the early days of the western hemisphere the first civilized settlements were decimated by yellow and dengue fevers. Before the turn of the century many of the early white settlements were destroyed by the same maladies, caused, for the most part, by man-made conditions. The cisterns and "centoes," or water wells, were an essential part of early communal life. This type of water supply did not give way in the United States until after the turn of the century. The primitive sources of rainwater storage, while sanctuaries and quenchers of thirst, were also ravenous pits of destruction which produced and sent forth hordes of beautiful little silver-scaled lyre-marked mosquitoes that left their impression on all of the new and budding civilizations of this hemisphere. The truth about this great scourge became known in 1898, and the last vestige of the panic disease, yellow fever, raised her ugly head in Florida in 1905.

Today in many respects we stand where we did in 1898, in a state of ignorance because we are building sanctuaries of death into the environments in which we now find ourselves living. In many residential areas of the state polluted and nonpolluted open road and streetside ditches produce vast hordes of Culex nigripalpus and Culex quinquefasciatus mosquitoes, known vectors of St. Louis encephalitis. In the field of conservation, as in the years of old with the Incas, Mayas and early white settlers, water storage is still considered a necessity for an expanding population, but we have forgotten our lessons of yesteryear.

Little consideration is given today to the thought of mosquito abatement. The main thought is to produce recreational areas for fishing, bird and other animal life, and storage areas to supply the water needs of vast metropolitan areas. Lest we forget, water can be destructive to the human race in more ways than one, if it is not properly supervised and maintained for the proper utilization of the human race.

It therefore behooves every citizen of Florida, including physicians, to see that mosquito-breeding conditions are maintained at the lowest level economically possible. Unless this precaution is taken, the day will soon come again in tropical and subtropical Florida when the mosquito will once more dog the steps of man, as it has throughout the trails of history.

It must always be remembered that wild birds and other animals are carriers of viruses and other diseases of man. It has been stated that each New Yorker daily inhales three micro-

grams of pigeon droppings, 36 per cent of which show positive Cryptococcus neoformans, a frequent cause of meningitis. The work of many people, societies and governmental organizations is projected to conserve and build up bird populations for hunting and for their aesthetic and psychological value in the populated areas. This brings about bird populations which are, in many instances, five times higher than normally found under natural conditions.

The desires of man can be met, but it means that he must carefully plan for the future. As far as economically possible, construction of cities must have the mosquito problem built out, and the water and flood control impoundments created adjacent to populated areas must be kept free of mosquito breeding.

John Mulrennan
Entomology

Wildlife Rabies

The rabies story goes on and on. Man has known about it for more than 20 centuries, and even though it has most likely been studied, researched, discussed and argued about more than any of the animal diseases transmissible to humans, it is still with us. From every present indication it is going to remain with us during the foreseeable future.

The problem of wildlife rabies is not a new one, as records indicate that it appeared in North America during the middle of the eighteenth century. For some years it was limited to the eastern seaboard and then spread to the Mississippi and eventually farther west. Now, most parts of the country experience it from time to time, either as an epizootic or in the enzootic form.

While methods of controlling rabies in domestic pets are well known, our wildlife population presents an entirely different picture. For quite some time Florida has recorded a rather large number of laboratory-diagnosed cases of rabies in wild animals. During the past 10 years rabies has been reported in the following species which are listed in descending order: raccoon, fox, bat, skunk, bobcat and flying squirrel. During this period the annual rate has varied from a high of 89 to a low of 27. Only a fraction of the cases in wildlife became a matter of record because it is a reasonable assumption that those occurring in the deep woods and other out-of-the-way places are not seen by anyone.

Rabies in Florida's wildlife not only has public health significance but it is also of concern to the state's livestock industry, especially in fox epizootics, as this species will readily attack farm animals. Reports of rabid skunks attacking swine are not uncommon. Rabid raccoons are apt to be engaged by the family dog, when they lose their fear of natural enemies and wander into inhabited areas.

Up to the present, little has been done except to set up transmission barriers between rabid wild animals and pets by the use of such procedures as the apprehension of stray dogs and cats, vaccination of pets and an occasional limited program of reduction of the wildlife population. Little is known about intraspecies transmission and practically no information is available on the interspecies spread in wildlife. An exception is the fox which will attack all species, including its own. A study of wildlife rabies in Florida, which extended over a period of a number of years, revealed many interesting features concerning the behavior of this disease, but it did not furnish information which would lead to eradication or complete control. Wildlife reduction as a technique for rabies control is effective in foxes at the peak of an epizootic. In skunks and raccoons it is acceptable on a small scale but it is expensive. In an enzootic it is expensive, most likely too much so to be feasible when one considers the results which are temporary in nature. The idea of attempting to reduce the bat population with a view of diluting or eliminating rabies infection does not seem to be feasible at this time because of the migratory habits of this species.

Since wildlife rabies is a problem that cannot be lived with forever, continued surveillance and more intensive research are considered to be essential. Private physicians can be of assistance with both of these aspects of control, if only by reason of manifested interest. More must be learned about the intraspecies and interspecies transmission. Some of the curbs which might be consider-

ed are the development and use of drugs and dispensing devices which will promote temporary sterility, the development and use of oral vaccines, and perhaps some other biological measures not yet recognized. Until a solution is reached, there will always be the constant threat of a person becoming infected from the bite of a rabid wild animal, and equally as dangerous, the spilling over of the infection from wildlife to unvaccinated dogs and cats.

James B. Nichols
Veterinary Public Health

Over 25? You Have 1.5 Chronic Diseases

Sir William Osler once said that the way to live a long life is to get a chronic disease and take good care of it. This is fine if one could choose the disease of his desire. To do so, however, is almost as difficult as selecting healthy grandparents who lived to a ripe old age.

Florida statistics show that 70 per cent of the deaths of our residents are due to heart disease, diseases of the blood vessels, cancer and diabetes. One might rationalize that death is inevitable and that one must die from some cause. We find, however, that our young and middle-aged men are being killed or crippled in great numbers by arteriosclerotic heart disease, coronary occlusion; that cancer is the leading cause of death of our Florida women between the ages of 35 and 54; and that the majority of nonwhite diabetic females are dead from the disease or its complications before the age of 45.

Careful studies conducted on the population of southeastern United States, including Florida, indicate that each person over the age of 25 has on an average 1.5 chronic diseases. Physicians are no exception as has been proved by the large number of undetected conditions uncovered when diagnostic procedures have been made available at large medical meetings.

What can be done? Are we too busy to seek preventive medical examinations? We do not have to await miracle cures or therapeutic breakthroughs to eliminate deaths from uterine cancer. Can the constant rise in the mortality rate due to cancer of the lung be reversed? I believe it to be our duty as physicians to tell our school children and our patients the true facts about the effect of smoking on the human body. Can we detect the coronary-prone person and prevent many such deaths in the future?

If we are to look for diabetes in the nonwhite female, the casefinding must begin prior to the age of 25 years. By 40 years of age a large percentage of diabetic women are dead from either the disease or its complications. Can we prevent diabetes or postpone its complications? Advice against intermarriage of diabetics and the enforcement of strict weight control in the prediabetic as well as the early diabetic patients are in order. Casefinding is best done by a true blood sugar estimation two hours postprandial. Fasting blood sugar estimations are now seldom determined as a casefinding procedure.

Glaucoma is the second cause of blindness in Florida. The insidious disease of chronic glaucoma can be detected in a few minutes by the simple test of tonometry. More permanent ongoing screening centers are indicated to find the early cases of the disease and to place the patient under competent medical control before permanent visual damage is done.

What is the common denominator of the big picture of prevention and early detection of chronic diseases? One method is by Health Profile Screening procedures. Screening is the presumptive identification of unknown and unrecognized disease or defects by the application of tests and examination that can be applied with ease and rapidity on apparently healthy persons. Screening tests are not diagnostic, but point to the persons who should consult their own physicians for further medical work-up. Health Profile Screening examinations may well be carried out in the offices of physicians, in hospital outpatient settings or in special centers operated under the direction of the local physicians and with the cooperation of the volunteer societies, the county health departments and other community agencies interested in the health of the people. Through screening, those persons most likely to need medical attention are referred to their physician. Thus the busy physician's time can be better utilized for early diagnosis and treatment.

J. E. Fulghum
Chronic Diseases

President's Page

Happy Birthday!

To have attained the ripe old age of 90 is a distinction that deserves recognition. Our guest of honor today is the Florida Medical Association. This gives us an opportunity to say right out in public some of the pleasant things we have been thinking about her all through the year. It is difficult to know where to begin.

Dr. Jere W. Annis last month wrote an editorial for The Journal in which he chose as a topic: "The Old Lady Shows Her Medals." In this delightful tribute he told a story of progress and achievement related to the development of the Association through the years. An objective point of view was obtained by keen study of the officials. And the observations were recorded by one who has made a magnificent contribution during his individual period of service. Naturally, we are all very proud of this grand old lady and are glad to be members of her family. May she continue to thrive and depend upon the loyal support of those who love and respect her!

The motorist, in proper operation of his vehicle, frequently makes use of his rear view mirror to alert him to hazards of the road. But it is equally important that the windshield be clear and that the view ahead be unimpeded. Our Association must prepare for the future while handling the problems of the present. None of us can be accurately prophetic. This philosophy was expressed by Sir William Osler in his address to Yale students on April 20, 1913. He emphasized, as a Way of Life, the importance of doing the day's work, of living the day to the utmost. Quoting Carlyle's familiar dictum, he said: "Our main business is not to see what lies dimly at a distance, but to do what lies clearly at hand." This sentiment was exemplified in his personal life with a very full and productive contribution to the progress of Medicine. Believing that the future is today, he lived earnestly and intently, as the best insurance for tomorrow.

The strength of our State Association lies in the sustained interest and efforts of the individual members, and the enthusiastic activity of her component County Medical Societies. Improved procedures, adaptable to the changing times, are essential for proper utilization of ideas and thoughts which originate individually. New challenges and opportunities for service are noted daily. Acceptance of these as our responsibility will, inevitably, lead to further progress. Our greatest hope for the future of Medicine in Florida is based upon the renewed enthusiasm and dedicated talents of our younger members. So many difficulties are not solved. Current developments and happenings within the organization sometimes produce criticism. Decisions are made in good faith by those delegated for this responsibility. But the mechanism for freedom of expression, and modifications of procedure when necessary, has been provided. A united front, meeting our problems as they arise, is essential here, as in any other large family. Our resources are adequate.

Approaching the conclusion of this tour of duty as your President, let me express appreciation to all of you for your confidence and trust during a trying period. The loyalty and enthusiastic response of so many have been heartening. One privilege of the Presidency is the opportunity to know and work intimately with many members of the Association. As one of the older members of the family, I hold the firm belief that our destiny rests in very capable hands. We are blessed with great talent and a potential for constructive service among the younger members throughout the state. They, in turn, will have access to the advice and experience of the veterans as they assume responsibility for policy and action. Never has there been more unselfish and dedicated effort on the part of a Board of Governors to make wise decisions for the betterment of the organization. Our Executive Staff has gone the extra mile in its desire to provide the things required for administration of a large and thriving corporation, designed solely for service to its membership and the public welfare.

As an indulgent mother, perhaps the Florida Medical Association on her birthday will forgive any honest mistakes which have been made during the past year. She will remember the fervent prayer of the sailor who said:

"Oh Lord! Thy sea is so great; and my ship is so small!"

Warren W. Quillian

Association News



President's Guest

Ninetieth Annual Meeting

May 7-10, Diplomat Hotel

Hollywood-by-the-Sea

Dr. Edward R. Annis, President of the American Medical Association, will be the honored guest of President Quillian at the 1964 Annual Meeting of the Florida Medical Association, to be held at Hollywood's Diplomat Hotel on May 7-10. He will be featured speaker at the General Session, scheduled for 11 a.m. on Friday, May 8.

This distinguished Miami surgeon is the second member of the Association to hold Medicine's highest office, and Association members take great pride in the outstanding record he is making as a spokesman for the profession. A native of Detroit, where he was born in 1913 and where he received his early schooling and academic training, Dr. Annis was awarded the M.D. degree by Marquette University School of Medicine, Milwaukee, Wis., in 1938. After practicing for eight years in Tallahassee, he moved to Miami where he has engaged in the private practice of surgery since 1946. Dr. Annis won national fame as a speaker and debater and served as chairman of the AMA's National Speakers Bureau before acceding to the presidency.

Throughout his career Dr. Annis has been particularly active in civic affairs and has served effectively in the political arena at local, state and national levels. The list of his achievements is long and impressive. His Florida colleagues rejoice in his able leadership in the battle for political, economic and professional freedoms and laud his bold stand for individual initiative and free enterprise. They extend to him a hearty welcome as one of their very own.



Editorials

The Entomological Research Center

The Entomological Research Center (ERC) at Vero Beach is a world-renowned institution in medical entomology. As a part of the Florida State Board of Health, it is unusual in its mission and consequently in its staff, its program, its facilities and its accomplishments. When Florida's legislature in 1951 established a center for research not only into the control of biting insects (a concern of many other laboratories) but concurrently into their biology, the stage was set for a multidisciplined attack on vectors of disease and purveyors of annoyance. The blend of these two approaches—learning how the insect lives while developing methods for its control—is notable here because both receive the ultimate in effort. The best in science and in technology join forces in a joint objective, and that objective is limited to a small but potent group of insects. Mosquitoes receive major attention, followed by sand flies and the rest of Florida's biting pests.

While the ERC is supported by the State of Florida, its senior staff members have supplemented the state's contribution with nine National Institutes of Health (U. S. Public Health Service) research grants aggregating over $200,000 per year. The staff includes 27 biologists and entomologists, 12 of them with a doctorate in science. The remainder of the staff of 57 is composed of an unusual variety of skilled craftsmen and workers.

The ERC's program is a large control research section and four biological research sections: Ethology, Ecology, Physiology and Biochemistry. The control research program is defined by current and anticipated problems in Florida's mosquito control districts while the biological researches are those most critically needed to improve present control methods or most likely to lead to new control methods. Control research falls naturally into three areas, (1) source reduction, or environmental control, (2) larviciding, or chemical control of immature stages, and (3) adulticiding, or chemical control of the winged insect. The Ethology section studies the life history and behavior of the insects. The Ecology section is concerned with environmental influences on development, behavior and populations. The Physiology section concerns itself with sensory abilities, nutrition, reproduction and other life functions, and the Biochemistry section investigates metabolism and energetics.

Located on 42 acres of land south of Vero Beach, between U. S. 1 and the Indian River, the ERC occupies several buildings which together contain 16 well equipped and versatile laboratories. Library, machine shop, dark room, drafting room and other adjuncts to research are an integral part of the whole. The salt marsh on the property has been developed into an unusual nursery designed to mass-produce mosquitoes for research. The surrounding woods are full of research apparatus and structures. Special areas for control, ethological and ecological studies are distributed over a 20 mile radius.

The accomplishments of the ERC can be gauged by its contribution to the mosquito control program in Florida and by its contribution to knowledge as reflected in published scientific and technical papers. By the former criterion, the research effort has yielded for Florida a uniquely distinguished mosquito control operation: effective source reduction through marsh canaling or flooding which has reduced salt marsh mosquito production to a small fraction of what it once was and to virtual annihilation in those counties which have completed their earth-moving program; effective larviciding with a radical innovation in formulation which circumvents the development of insecticide resistance while becoming also the safest method from the fish and wildlife protection viewpoint; and effective adulticiding with the least expensive and safest operation from the hu-

man health standpoint. The publication criterion is met, to date, with 135 papers in 25 scientific and 12 technical journals.

The first responsibility of the ERC is to Florida, where the health of the public must be safeguarded against mosquito-borne diseases, from the once prevalent but now eradicated trio of yellow fever, malaria and dengue to the emerging threat of several arboviruses—the mosquito-borne encephalitides. These latter, of which the St. Louis encephalitis epidemic of 1962 in the Tampa Bay area was a cogent reminder, could work havoc to Florida's tourist-oriented economy. And this economy is, in addition, pointedly responsive to those biting insects which may not presently be vectors of disease. The ERC must then provide the state with the know-how to shield its residents and visitors from those biting insects which the terrain and climate tend to produce in such unhealthy and annoying abundance.

To the world and to medical science the ERC contributes findings in the basic biological sciences which are the necessary and inevitable bonuses of its research interests. Thus its development of the most sensitive microrespirometer known, capable of measuring the oxygen consumption of a single mosquito minute by minute, of neurodissection permitting excising and transplantation of secretory brain cells in the mosquito, of microanalytic techniques for fats, glycogen and sugar in mosquitoes, and of immunologic and ethologic techniques applied to self-fertilized fish, have materially advanced fundamental understanding in such areas as metabolism, neurohormones, lipid synthesis, genetics and sex determination. Through such research products and by-products, the ERC hopes to continue contributing to the health and economy of Florida and the world.

Maurice W. Provost
Director

SPEED UP REGISTRATION

Have Your Badge Stamped by Machine

Bring Your Plastic Membership Card To

The Annual Meeting, May 7-10, Hollywood

Breaking Barriers

The twentieth century will surely go down in history as the years of "broken barriers." The Wright brothers breached the flight barrier in 1903; Lindbergh broke it wide open in 1927. Major Yeager pierced the sound barrier only a decade ago. Man was on this earth almost one million years before running a four minute mile; yet once accomplished, three men were soon doing it in the same race; and as of today, the feat has been duplicated 74 times.

Let us not worry about who is first to the moon; once accomplished, others will immediately and easily follow suit.

Columbus was 45 days crossing the Atlantic and it still requires three hours to jet from the East to the West Coast; yet John Glenn did it in 11 minutes and 10 minutes respectively.

And all is done with such ease and amazing safety, for the missile has carried man four billion miles without the slightest injury. No other form of transportation can claim a 100 per cent safety record.

Medical barriers are now being crossed almost daily, but it took thousands of years for us to make the initial breakthrough—such as insulin, antibiotics, Salk vaccine and heart surgery—with the best yet to come.

Only two major barriers have withstood the assaults of time and man's ingenuity: the religious and the thought barriers. Not only have they never been broken, they are not even bent. Great men have attempted to peer beyond their enclosures but to no avail. I predict that in the not too distant future a man of great depth and unlimited vision will break the binders, ascend the mountain and view the valley that will truly release man's soul. It will come only after he has unleased the potential thought-capacity of his now untapped millions of brain cells, and becomes capable of thinking far beyond one billion to the nth degree. When this happens, men will discontinue their arguments about the 40 hour work week, for one hour per day four days per week will do the job much better than it is being performed today.

That is yet ahead of us. Today's speeds would take a 65 year old man to Venus in 145 days and he will be only 41 years of age the minute he sets foot on its swirling surface.* Just a

*Venus has a 584 day orbit; earth 365 and six hours.

word of warning to those who dream of turning backward time in her flight: The only noticeable change will be economic—his old age pension will be discontinued and he will have to wait 24 years before "foreign aid" sets in again. That is a long time to wait for pay day in a hostile environment.

Environment is the limiting factor to man's continuing existence. The body ever engages in a never ending battle with the things and bugs about it. The state that we call death simply means that the organism has lost the battle with its environment.

Whether we are in space or deep in the ocean, the battle remains the same. We must keep ourselves surrounded by a livable climate or develop a body that will be able to overcome the odds.

This all adds up to a man-made artificial environment when we leave our natural habitat. Man's first effort at occupying another planet should be one most nearly like his own (not the moon). If there is to be a gravity differential, it should be greater, not less, than our earth.

Earth man can adjust to life on the moon, but moon man can never live for long here. The vascular system would adjust quite readily to carrying one-sixth of its present load (a 150 pound man weighs only 25 pounds there). Once acclimated, he would be committed forever there or to a planet with the same or less gravitational pull. Unquestionably, the breakdown of vascular walls and other complications would get him before he could possibly return to earth.

We do not know what reduced or zero gravity will do to our cholesterol, bone marrow or even our reproduction rate, but the latter calls for a book within itself.

Scientists realize that the hardiest of men and animals are required for space and pressure living; not more than one out of every 200,000 can be expected to withstand the rigors of planetary travel. This knowledge has resulted in many animal experiments pointed towards the development of a more sturdy species. A group at the University of California has apparently succeeded in breeding a strain of "chronic-acceleration-resistant" chickens.

Psychological aspects present more insurmountable problems than do the physical entities. This fact has been clearly demonstrated by the experiments performed in the twin passenger capsule simulated trips to the moon by the Brooks Air Force group in Texas. Psychological readjustment will take centuries for most of us and there is but little that we can do to speed it up.

One does not have to be in space to become confused. During the past 10 years the Air Technical Intelligence Center has examined more than 6,000 reports related to Flying Saucers. These people do see planes, vapor trails, balloons, parachutes, missiles and artificial satellites. Some are secret, some are hallucinations, but all are explainable.

The entire story of extraterrestrial travel is easily understood if we will just realize we are now able to take off tomorrow, travel 24 hours today and arrive yesterday. We must not be disturbed when flying west, on one of our 2,000 mph passenger jets now on the boards, if we see the sun rapidly "set" in the east.

Further, do not be disturbed by the "experts" saying that we must go to the moon. Take it from this "expert" that nothing can be done on the moon that we cannot do better, faster and cheaper on the earth.

I know that it is confusing to hear so many conflicting statements and theories and I can help you but little with your differentiations; however, this may help: Beginning now, with this essay, judge all that you read and hear by what was said, not who said it; what was done, not who did it, and why it was said or why it was done. By so doing you can eliminate the public relations men, the salaried promoters, the land speculators and other conflict-of-interest people who may appear to have an unlimited knowledge of today's space requirements.

The problems of space travel go well beyond the economic, psychological and physical. What about the moral laws on Mars? Will the vacationer there still be bound to his earthside battle-ax? Too, the "experts" are worried about the bacteria that we might send to Mars and what monster Mars might send back to us. I am more worried about what Washington sends us and what we will have to send back to Washington.

Though we dawdle on the fringes of great and unbelievable break-throughs, I am led to believe that the outstanding man of the twentieth century will not be an astronaut, a moonnaut, a son-of-a-naut, a general, a scientist, nor a politician, but simply a practical business man who can give us a balanced federal budget, pay 1 per cent on our national debt annually and continue to be re-elected year after year. I fear that such a man is yet unborn and that his mother is already dead.

The story of breaking barriers cannot be

closed appropriately with a final summary, paragraph or prediction for much of their history lies ahead and with a future so fantastic that it defies belief. Yet I am convinced that the beloved poet Walt Whitman must have had 1964 in mind more than a century ago when he penned the following lines:

> The world, the race, the soul—in space and time the universes,
> All bound as is befitting each—all surely going somewhere.

JAMES BASIL HALL

A Gentleman Who Knew His Own Mind

The consternation of newcomers to Jacksonville when they are confronted with not one but three health departments—city, county and state—leads one to conjecture on how Dr. J. Y. Porter, the first State Health Officer, was able to establish the Florida State Board of Health in that city. After due consideration Jacksonville was selected as the most desirable point, all things being considered including superior facilities for rapid communication and transit, for location of the office of the Board and was the place of residence of the President of the Board, Dr. R. P. Daniel. In 1889 the state capitol had been established at Tallahassee for over 65 years and no other department of government seems to have had the temerity to suggest removal to another spot, especially one which involved a journey of several days. Dr. Porter, however, was no ordinary man. Strong-willed, farseeing, a native of Key West, there have been those who suggested that he chose a port city so that he could more easily use coastal steamers to reach his island home. But a review of events reveals that this was only an incidental bonus. Dr. Porter was independent financially as is shown by the fact that in 1889 he retired from the United States Army at the age of 42 (a thought which will make many a reader envious). He was convinced that Jacksonville would be a center of transportation and that Tallahassee was out-of-the-way—and so to Jacksonville he came. Perhaps he was further motivated by his stay in Jacksonville during the disastrous yellow fever epidemic of 1888. The epidemic, which began in the southern part of the state, spread rapidly, culminating in a paralyzing epidemic in Jacksonville. It rapidly became a ghost city and when a call went out for assistance, Dr. Porter answered it. For his untiring work both houses of the Florida Legislature lauded him for his gratuitous service to the City of Jacksonville, and the Jacksonville Auxiliary Sanitary Association made him a gift of a magnificent Swiss watch set with rubies and diamonds.

Though as early as 1873, at the urging of a Committee of the Florida Medical Association, a legislative bill had been introduced to provide for an appropriation of $200 (sic) for a health program, the bill had been defeated mainly because the amount was considered exorbitant. But following the yellow fever epidemic and the confusion which had been precipitated by numerous independent regulations by county boards of health, a State Board of Health was established in 1889. Dr. Porter was offered the post of State Health Officer at the munificent salary of approximately $3,000 a year. He and one clerical worker were "it"—for several months.

Though Dr. Porter died in 1927, many of his ideas remain as a bulwark of present day public health practice. His statement, "The day is close at hand when security of human life will be recognized for what it is—the real basis of all values," remains an abiding tenet. Health education for the masses, the gathering of vital statistics, the improvement of health conditions so as to attract tourists, isolation of patients with tuberculosis, premarital and antepartum examinations, better water supplies and sewage systems—all of these programs which he advocated are still as current as they were in 1889.

Other State Health Officers have come and gone—many making great contributions to Florida's health, including Wilson T. Sowder, M.D., the incumbent since 1945. But the effectiveness of any State Health Officer is contingent upon the definition of policy and support which he receives from his Board members, appointed by the Governor for four year terms. A survey of Board presidents reveals that out of 14, seven (including the last six) have been private physicians, representing a wide range of professional interests: R. P. Daniel, Jacksonville (1889-1890); H. Mason Smith, Tampa (1930-1932); N. A. Baltzell, Marianna (1933-1939); Shaler Richardson, Jacksonville (1940-1941); Herbert L. Bryans, Pensacola (1941-1957); Charles J. Collins, Orlando (1957-1959); John D. Milton, Miami (1960-1961); Eugene G. Peek Jr., Ocala (1961-).

E.R.

Others Are Saying

Time Magazine - Source of Information on Ethical Drugs

Senator Estes Kefauver with his widely publicized hearings on the pharmaceutical industry and the advertising of ethical drugs, had many motives and many designs but we will wager that he never anticipated that *Time Magazine* would become a major source of advertising for ethical drugs. Yet this bizarre happening has really come to pass.

We have at hand a copy of Time Magazine received by a physician who has been a subscriber to the magazine since its founding. In it is a special tearout four page insert of the "Roche Report—Frontiers of Medicine." On the first three pages are indeed research reports of the kind physicians read in medical magazines, including color photographs of scabies of the buttocks. On the fourth page is a full page color ad for "Gantanol sulfamethoxazole" which is used for the treatment of "common respiratory, genitourinary and soft tissue infections in general practice."

Along with the special insert of advertising most usually found in a magazine of general circulation, is a mimeographed letter from the publisher of Time, Mr. Bernhard M. Auer, which reads:

Dear Doctor:

This is the second issue of TIME to incorporate a special advertising section sent only to doctors. Printed on slightly heavier paper than the regular magazine pages, it is readily detachable for filing and reference.

The insert in this issue is the second in a special medical service series entitled FRONTIERS OF MEDICINE prepared and sponsored by Roche Laboratories. Messages from other leading pharmaceutical companies will follow in later issues.

This material, of course, is prepared exclusively for the medical profession, not for the general public. So, if your copy of TIME goes into the waiting room, you will probably want to remove the insert first.

We hope you will find this section interesting and useful.

Cordially,
Bernard M. Auer
Publisher, Time

We would note that the advertising of the Roche Laboratories, thus clandestinely clipped into Time for removal before the patients see it in the outside waiting room, contains none of the stipulations of advertising in medical journals where the manufacturer is required to give the side-effects and contraindications for the product and to give citations from the medical literature on the clinical tests of the drug. Apparently there is one set of rules for medical journals and another for Time Magazine.

In any event the physician who received this advertising, tear-out insert wrote a letter to Time which said in part:

February 27, 1963

Time
Time & Life Building
Rockefeller Center
New York 20, N.Y.
Dear Sir:

Each issue of Time is read by many others than the doctor himself. Most of my colleagues as I, subscribe to Time for our waiting rooms. To find such advertising about highly sensitive drugs is not only against all our policy in supplying reading material in a waiting room, it also leads to embarrassing questions.

Should you continue this advertising my subscription for my waiting room will be cancelled.

* * *

The reaction of one physician to this type of advertising is serious enough but there are far deeper ramifications of this new outlet now available to manufacturers of ethical drugs. Here are a few:

1. Following the Kefauver hearings the ethical drug companies had a period of indecision and uncertainty until they learned the rules and regulations, on how far they had to go on what the Senator called full disclosure . . . citing the side effects and contraindications for the various drugs. Ethical drug ads that once could have appeared on one page of a medical magazine sometimes required a two page spread to give *all* the facts. The government argued that the physician could not be trusted to read all the clinical literature and therefore the facts had to be spelled out for him in the same advertisement.

2. As a result of this ruling, the advertising budgets of the drug manufacturers were sharply reduced for medical journals . . . and they still are. Typically the advertising income of medical publications is down by some 20 per cent from the pre-Kefauver days. As a result the editorial content of medical journals, generally, has been reduced in proportion.

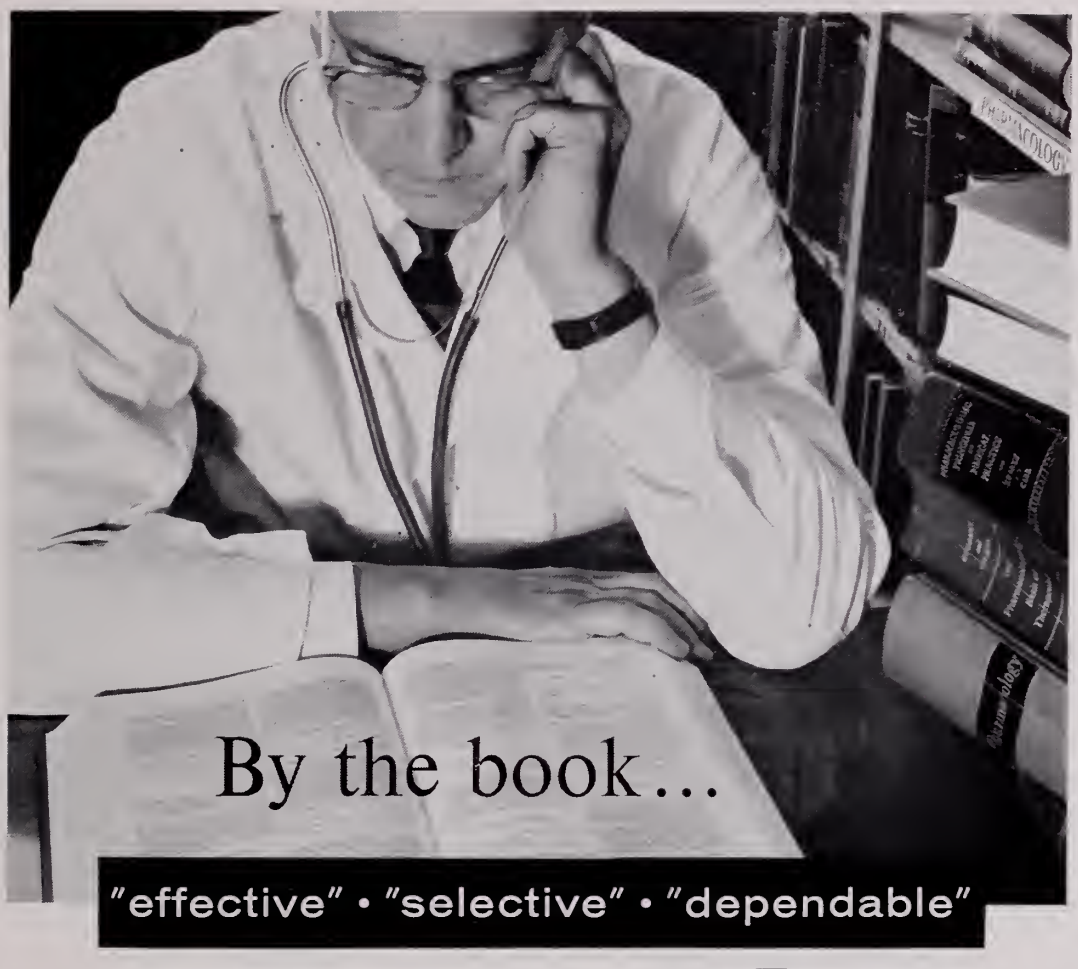
3. The ethical drug companies, however, still needed to reach physicians with their advertising message. Thus they became—as they would call it—increasingly selective, and they began to think about duplication of advertising coverage. Thus they stayed in the largest of the national medical magazines (either those sold on subscriptions or those on a give-away-basis) and shaved their budgets at the level of state and county publications.

4. However, when the advertising managers of drug companies like Roche Laboratories . . . thought through the problem of duplication they pushed on to the next stage and asked the question, "Why stop here? Why not reach doctors through a mass circulation magazine which they probably read more often then their own medical journals?" And—with the willing assent of Time Magazine—we now have the insert ad referred to.

5. How far will it go? One key differential between a proprietary drug for over-the-counter sale, and an ethical drug, was that the patent medicine was advertised to the public and the ethical drug was advertised only in medical magazines or by direct mail to doctors to their private offices. Under the new and ingenious—and we believe unethical—plan in Time Magazine, the doctor in his office is now given the burden of keeping the ethical drug "ethical"; by making sure that he tears out of each issue the professional medical insert. Will doctors do it? Should doctors do it?

6. Finally we would plead for a return to realism in ethical drug advertising and ask the manufacturers to help support medical society publications by their advertising of ethical drugs. Maybe this is old-fashioned; and maybe Time Magazine truly is a better source of information for the practicing physician. But we think not and we think that practicing physicians will begin to scan their own medical publications and note which companies advertise there and which do not. And when they do, we predict some revolutions in the advertising budgets of the pharmaceutical industry.

Reprinted from NEW YORK MEDICINE, April 5, 1963.
THE BULLETIN
HILLSBOROUGH COUNTY MEDICAL ASSOCIATION
JUNE 1963



PRO-BANTHĪNE®

BRAND OF propantheline bromide

For Ten Years... the Standard Anticholinergic

Many studies by many investigators over many years have established Pro-Banthīne (propantheline bromide) as the standard anticholinergic in the management of peptic ulcer and other gastrointestinal disorders.

It Is Effective—Hundreds of comparative laboratory and clinical trials and innumerable gratified patients have made Pro-Banthīne (propantheline bromide) the most widely-prescribed medication in its class.

It Is Selective—Its major effect is on the gastrointestinal and urogenital tracts. Secondary activity when noticeable seldom passes the point of temporary annoyance.

It Is Dependable—Moderate doses reduce gastric secretion and acidity and diminish gastrointestinal hypermotility. The usual dosage may be safely doubled or tripled to suppress symptoms in patients with severe or refractory conditions.

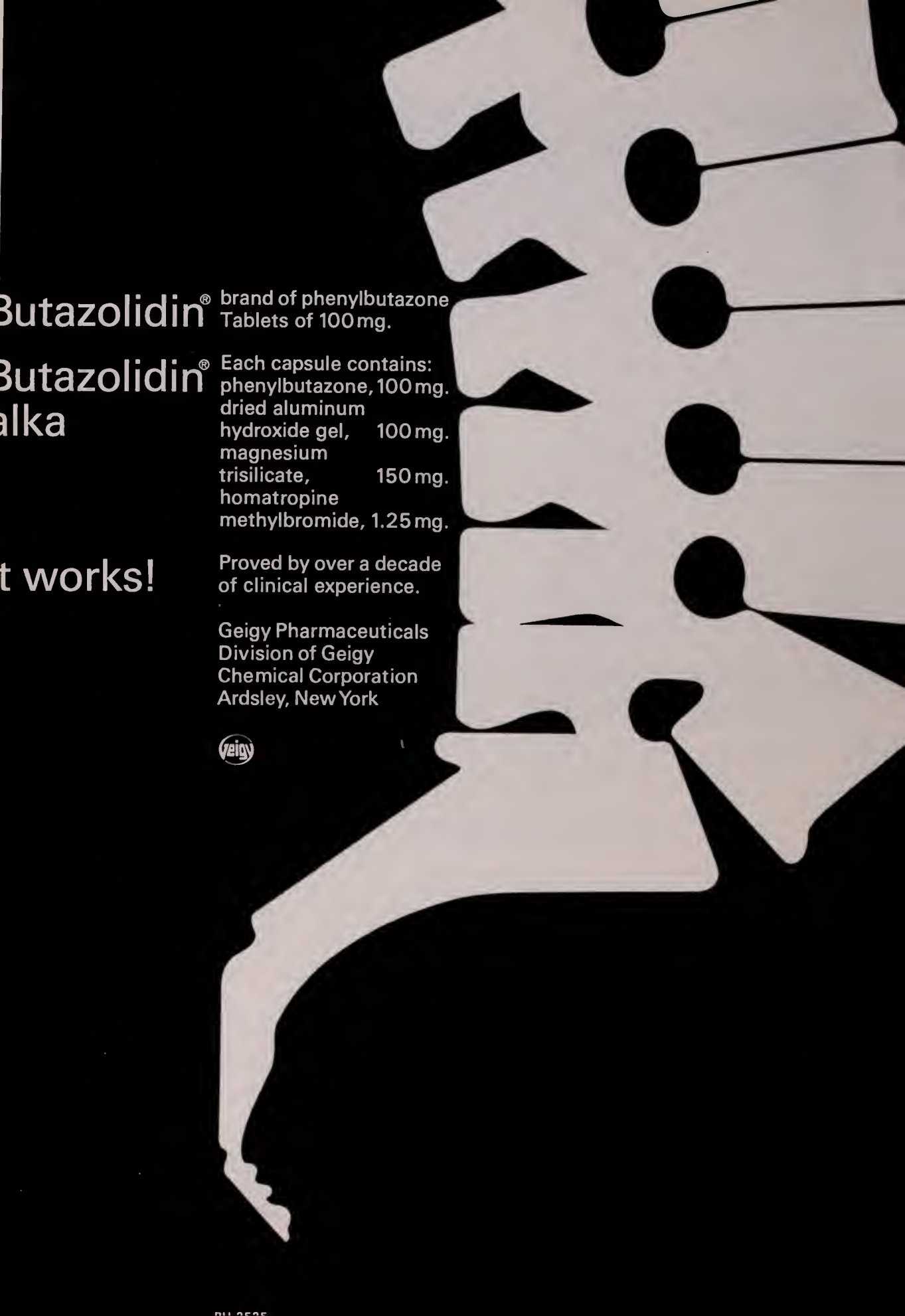
These qualities have won such wide recognition in standard texts on pharmacology and therapeutics that to prescribe Pro-Banthīne (propantheline bromide) is truly to prescribe "by the book."

The usual adult dosage is one tablet of 15 mg. with meals and two at bedtime.

Side Effects And Cautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur with Pro-Banthīne (propantheline bromide). It is contraindicated in patients with glaucoma or severe cardiac disease.

Pro-Banthīne (propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

G. D. SEARLE & CO.
CHICAGO, ILLINOIS 60680
Research in the Service of Medicine

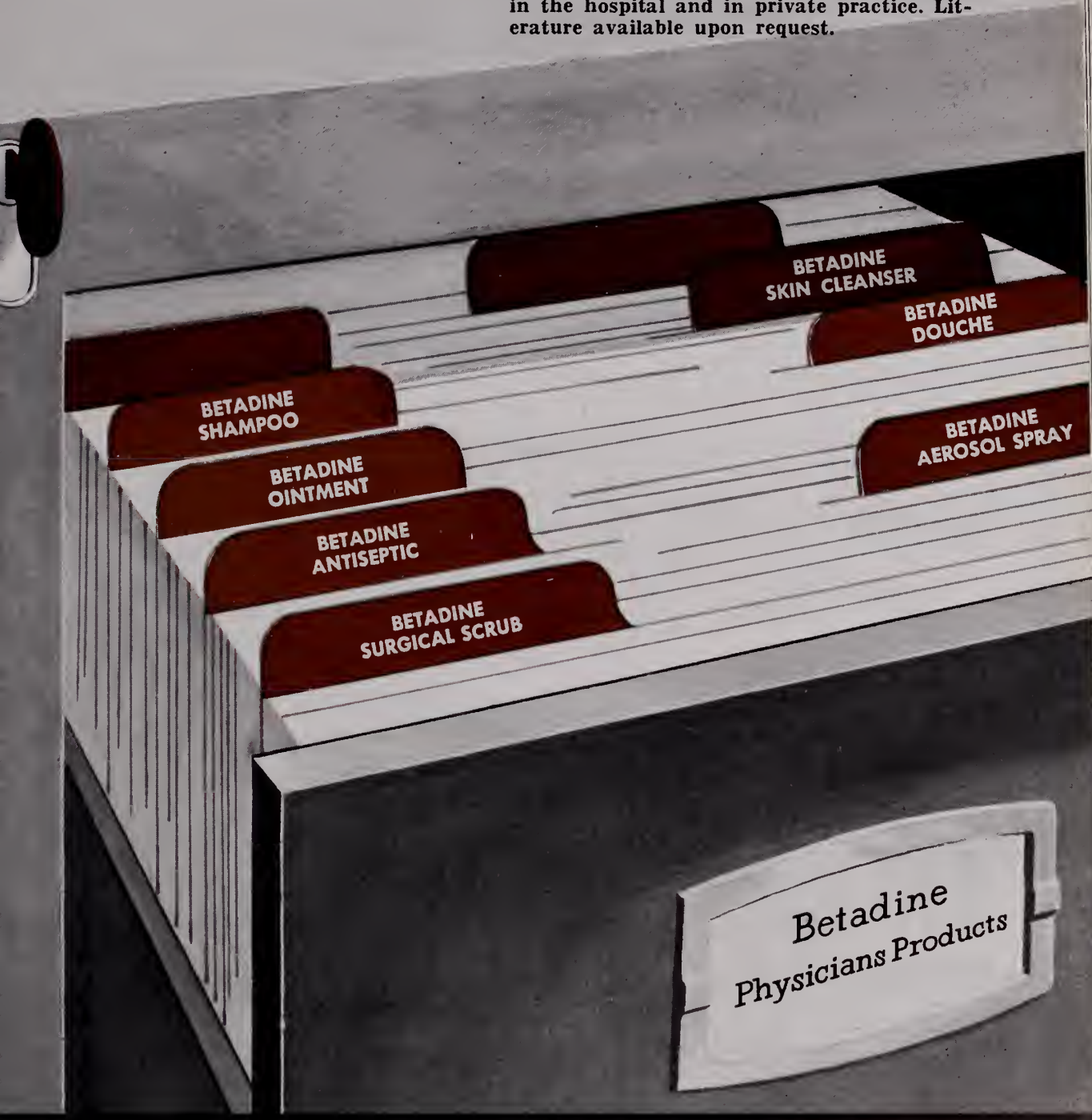

Butazolidin®
brand of phenylbutazone
Tablets of 100 mg.
Butazolidin®
Each capsule contains:
phenylbutazone, 100 mg.
dried aluminum
hydroxide gel, 100 mg.
magnesium
trisilicate, 150 mg.
homatropine
methylbromide, 1.25 mg.
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t works!
Proved by over a decade
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Betadine®
Povidone-Iodine Products
unlock a wide range of usefulness

Betadine Products, in all seven dosage forms, contain povidone-iodine, a complex of polyvinylpyrrolidone and iodine, providing all the germicidal properties of elemental iodine . . . yet Betadine (povidone-iodine) is nonirritating, nonsensitizing, and nontoxic to skin or mucosa.

Betadine Products are effective in preventing and treating a variety of infections frequently encountered in the practice of otolaryngology, orthopedics and orthopedic surgery, obstetrics and gynecology, oral surgery, pediatrics, surgery and dermatology.

The clinical results reported under various conditions of use make Betadine (povidone-iodine) preparations valuable adjuncts both in the hospital and in private practice. Literature available upon request.



PHYSICIANS PRODUCTS CO., INC.
PETERSBURG, VIRGINIA

News

Dr. Albert V. Hardy, Assistant State Health Officer, Jacksonville, has taken a three months' assignment through the United States agency for International Development to establish a public laboratory for the country's Ministry of Health in Libya.

All applications and letters of request for the American Board of Obstetrics and Gynecology must be filed by July 1, 1964 with Clyde L. Randall, M.D., Secretary, American Board of Obstetrics and Gynecology, 100 Meadow Road, Buffalo, N. Y. 14216.

"Evolving Concepts in Pulmonary Disease," is the title of the Second Annual Postgraduate Course in Radiology presented by the Department of Radiology of the University of Miami School of Medicine, March 18-21 at the Fontainebleau Hotel, Miami Beach.

The Florida Diabetes Association will conduct its Annual Seminar on Diabetes and Related Endocrine Disorders, Sept. 30-Oct. 2, at the Balmoral Hotel, Miami Beach. Registration fee is $20. and the number of registrants is limited to one hundred and twenty-five. Complete programs are being printed and will be available soon from George F. Schmitt, M.D., President, Florida Diabetes Association, 30 S. E. 8th St., Miami 32, Florida.

Dr. Edward D. Norton has been elected a member of the Executive Committee, Section of Ophthalmology, of the Southern Medical Association. Their Annual Meeting will be held in Memphis, Tennessee on November 16-19. Papers are now being accepted up to May 15 for presentation at this meeting. For further information write Dr. George S. Ellis, Secretary, 812 Maison Blanche Building, New Orleans, Louisiana.

The Annual Meeting of the American Academy of Physical Medicine and Rehabilitation will be held on August 24-27, 1964 at the Statler-Hilton Hotel in Boston, Massachusetts. It will consist of formal lectures as well as educational seminars in the fields of Disability Evaluation, Forensic Physiatry and Muscle Diseases.

the most widely prescribed peripheral vasodilator...

ARLIDIN
(NYLIDRIN HCl)
increases blood flow...



IN CEREBROVASCULAR INSUFFICIENCY
where vascular insufficiency may cause such symptoms as mental confusion, diplopia, fatigue, apathy, and behavior problems.



IN PERIPHERAL VASCULAR DISEAS
where ischemia causes mu
distress—pain, spasm, ac
intermittent claudication;
coldness, numbness or
ulceration of extremities.

Books Received

Elements of Medical Statistics. By J. V. Smart, B.Sc., M.I. Biol., F.S.S. Pp. 136. Price $7.50. Springfield, Ill., Charles C. Thomas, Publisher, 1963.

The Care of the Geriatric Patient. Edited by E. V. Cowdry, Ph.D., Sc.D. (Hon.), F.R.M.S. (Hon.). Ed. 2. Pp. 566. Price $11.85. St. Louis, The C. V. Mosby Company, 1963.

Current Pediatric Therapy. By Sydney S. Gellis, M.D., and Benjamin M. Kagan, M.D. Pp. 747. Price $16.00. Philadelphia, W. B. Saunders Company, 1964.

Atomic Energy Encyclopedia in the Life Sciences. By Charles Wesley Shilling, M.D., D.Sc., with the assistance of Miriam Teed Shilling, M.A. Pp. 474. Illustrated. Price $10.50. Philadelphia, W. B. Saunders Company, 1964.

Pathogenesis of Leprosy. Ciba Foundation Study Group No. 15. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A. Pp. 101. Illus. 19. Price $2.95. Boston, Little Brown and Company, 1963.

Elementary Medical Statistics. By Donald Mainland, M.B., Ch.B., D.S.C., F.R.S.C., F.A.S.A. Ed. 2. Pp. 381. Price $9.00. Philadelphia, W. B. Saunders Company, 1963.

A History of Medicine in South Carolina 1670-1825. By Joseph Ioor Waring, M.D. Pp. 407. Illustrated. Price $7.50. Charleston, S.C., South Carolina Medical Society, 1964.

Cancer of the Stomach. By William H. ReMine, M.D., M.S. in Surgery, F.A.C.S., James T. Priestley, M.D., M.S. in Experimental Surgery, Ph.D. in Surgery, F.A.C.S., Joseph Berkson, M.D., D.Sc., and Members of the Staff of the Mayo Clinic. Pp. 225. Illustrated. Price $11.50. Philadelphia, W. B. Saunders Company, 1964.

Handbook of Legal Medicine. By Alan R. Moritz, M.D., and C. Joseph Stetler, LL.B., LL.M. Ed. 2. Pp. 239. Price $5.75. St. Louis, The C. V. Mosby Company, 1964.

Case Studies in Obstetrics and Gynecology. By F. Jackson Stoddard, M.D. Pp. 312. Illustrated. Price $8.50. Philadelphia, W. B. Saunders Company, 1964.

Gastroenterology. By Henry L. Bockus, M.D. Ed. 2. Vol. II. Pp. 1241. Illustrated. Price $28.00. Philadelphia, W. B. Saunders Company, 1964.

Lysosomes, Ciba Foundation Symposium. Edited by A.V.S. deReuck, M.Sc., D.I.C., A.R.C.S., and Margaret P. Cameron, M.A. Pp. 446. Illus. 79. Price $11.50. Boston, Little Brown and Company, 1963.

Appraisal of Current Concepts in Anesthesiology. Edited by John Adriani, M.D. Volume 2. Pp. 478. Price $10.75. St. Louis, The C. V. Mosby Company, 1964.

Pediatric Therapy. Edited by Harry C. Shirkey, B.S. (Pharm.), M.D., F.A.C.P. Pp. 1144. Illustrated. Price $16.50. St. Louis, The C. V. Mosby Company, 1964.

Current Diagnosis & Treatment. By Henry Brainerd, M.D.; Sheldon Margen, M.D., and Milton J. Chatton, M.D. Pp. 867. Price $9.50. Los Altos, Calif., Lange Medical Publications, 1964.



CIRCULATORY
ORDERS OF THE
ER EAR

re decreased blood flow results
earing loss (sudden onset),
tus, and vertigo.

VASODILATIVE / VASORELAXANT

ARLIDIN®
(NYLIDRIN HCl)

decreases resistance in arteries and arterioles in skeletal muscle, in the brain, and possibly in the eye and inner ear • increases cardiac output (minute stroke volume) without significant changes in pulse rate or blood pressure • especially useful in enhancing blood flow in ischemic tissues • essentially safe, well tolerated, with rapid and sustained response • economical

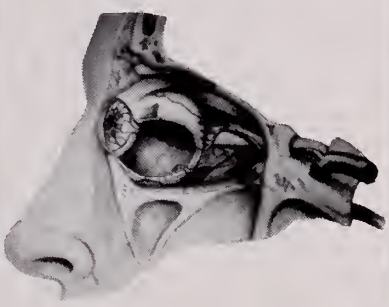
use with caution in the presence of a recent myocardial lesion, severe angina pectoris, and thyrotoxicosis.

contraindicated in acute myocardial infarction.

Protected by U. S. Patent Numbers: 2,661,372 and 2,661,373

u.s. vitamin & pharmaceutical corp.

800 Second Ave., New York, N.Y. 10017



IN CIRCULATORY
DISORDERS OF THE EYE

where there is vasospastic and circulatory impairment.

Available in 6 mg. scored tablets, and 5 mg. per cc. parenteral solution.



An open letter on a new concept in cigarette filtration from the makers of new LARK cigarettes

DEAR DOCTOR: In the recent report of the Surgeon General's Advisory Committee on Smoking and Health, attention was drawn to the inhibitory effect of cigarette smoke on respiratory cilia. On page 34, the Report states: "Components of the gas phase of cigarette smoke have been shown to produce various undesirable effects on test animals or organs. One of these effects is suppression of ciliary transport activity, an important cleaning function in the trachea and bronchi (Chapter 6, p. 61 and Chapter 10, pp. 267-270)."

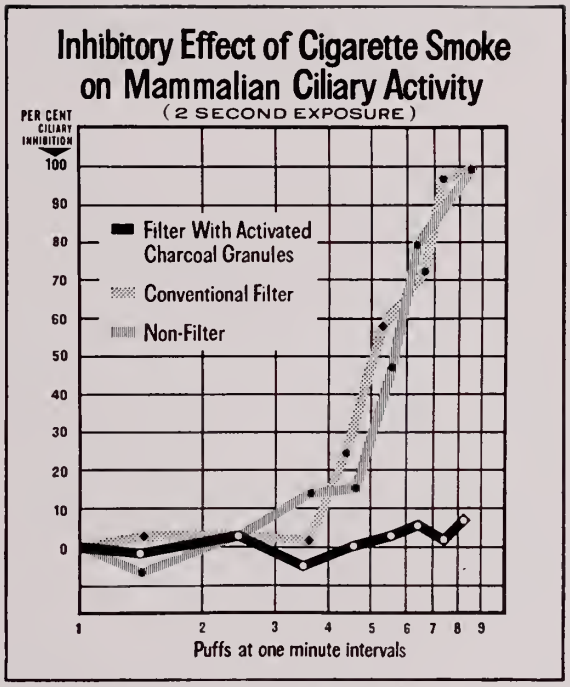
The Report also notes that there is a cigarette filter containing special charcoal granules which reduces certain gases which inhibit the activity of mammalian respiratory cilia. On page 61 of the Report it states: "Activated carbons differ markedly in their adsorption characteristics. Carbon filters previously employed in cigarettes do not have the specific power to scrub the gas phase. It has been reported that a filter containing special carbon granules removes gaseous constituents which depress ciliary activity (28)." The reference cited is "New England Journal of Medicine" (Kensler, C. J. and Battista, S. P., *269:* 1161-1166, November 28, 1963).

In 1954, Liggett & Myers Tobacco Company began a broadly based program of biological research on tobacco smoke which has been conducted in the Life Sciences Division of Arthur D. Little, Inc., Cambridge, Mass. In recent years, this research has centered on the gas phase of cigarette smoke, and the development of a specially treated charcoal-granule filter. This filter materially reduces the gases in cigarette smoke which contribute to the inhibition of the activity of mammalian

respiratory cilia in *in vitro* experiments. (see chart.)

Dr. Kensler points out in his paper referred to above: "Although it is recognized that these *in vitro* findings may not be directly extrapolated to the effects of cigarette smoke on human pulmonary tissue the use of the charcoal-granule filter will obviously reduce the level of exposure of the non-ciliated as well as ciliated bronchial and alveolar cells to potentially harmful smoke components."

The specially treated charcoal-granule filter discussed in the Kensler and Battista paper was the prototype of the one which is now available to the public on Lark cigarettes. Since some of your patients may have heard of this filter through the lay press, and may inquire about its basis in science, we believe you may wish to have the information at hand.



(Data from figure 6, page 1165, "New England Journal of Medicine," November 28, 1963)

Chart shows inhibition of the mammalian ciliary activity by the irritating gases in cigarette smoke:

1. The screened lines represent conventional filter and non-filter cigarettes and show how they produced 50% ciliary inhibition after 5 to 6 puffs and 100% inhibition after 7 to 8 puffs.

2. On the other hand, the filter with activated charcoal granules, represented by the solid black line, produced no significant inhibition (less than 10%) when the whole cigarette (8 puffs) was smoked.

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Deaths

Beardall, Harold Martyn, Orlando; born in Sanford on Feb. 5, 1885; Louisville and Hospital Medical College, Louisville, Ky., 1908; served a two year internship at New York City Hospital, and later had other postgraduate work at St. Luke's Hospital, Chicago, and Boston City Hospital; had engaged in the general practice of medicine in Orlando since 1913; was a veteran of World War I, attaining the rank of major in the Army Medical Corps; was a past president and secretary of the Orange County Medical Society; held membership in the American Medical Association and the Southern Medical Association; died January 22, aged 78.

Boyce, John Clifford, Sanford; born in Lachute, Que., Canada, on March 13, 1899; McGill University Faculty of Medicine, Montreal, Que., Canada, 1924; served an internship at Montreal Western Hospital, and completed a residency at Mt. Carmel Hospital, Columbus, Ohio, in 1929, taking other postgraduate work at Cook County Hospital, Chicago, in 1935; engaged in the general practice of medicine in Solon, Maine, from 1925 to 1928 and in Fremont, Ohio, from 1929 to 1951; had practiced in Sanford since 1951; was president of the Sandusky County Medical Society in Ohio from 1942 to 1946 and of the Seminole County Medical Society in 1954; served as selective service medical examiner for four years; was a member of the American Medical Association and the American Academy of General Practice; died Dec. 18, 1963, aged 64.

Brillhart, Harry Lester, Jacksonville; born in York County, Pa., on May 8, 1884; University of Maryland School of Medicine, Baltimore, 1912; served an internship and a residency at Mercy Hospital, Baltimore; entered the general practice of medicine in Jacksonville in 1914 and was associated with Dr. P. C. Perry for many years; was physician for The Florida Christian Home for the last 10 years of his half century of practice; was a member of the Southern Medical Association and the American Medical Association; died Dec. 14, 1963, aged 79.

Dell, James Maxey, Sr., Gainesville; born in Gainesville on Feb. 2, 1880; Atlanta College of Physicians and Surgeons, now Emory University School of Medicine, 1902; engaged in the general practice of medicine in Gainesville for more than half a century; was a past president of the Alachua County Medical Society and a former vice president of the Florida Medical Association; was a state senator at one time and mayor of Gainesville several times; was a major in the Medical Corps Reserve; was a life member of the Florida Medical Association and the American Medical Association; died February 3, aged 84.

Gorman, John Malcolm, Jacksonville; born in Augusta, Ga., on April 10, 1896; Medical College of Georgia, Augusta, 1924; served an internship at the Chicago Lying-In Hospital, Chicago, and a residency at Fresno County Hospital, Fresno, Calif., practiced obstetrics and gynecology in Jacksonville from 1928 to 1941; served during World War II as Ships Surgeon in the United States Merchant Marine from 1942 to 1944, when he was discharged from active duty with the rank of major because of physical disability; resumed the practice of his specialty in Fresno for a year before returning to Jacksonville permanently in 1946; was a member of the American Medical Association; died Dec. 19, 1963, aged 67.

Griffin, John D., Lakeland; born in Tifton, Ga., in 1879; Atlanta College of Physicians and Surgeons, 1904; engaged in the general practice of medicine in Lakeland for a short time and then in Pierce; in 1911, returned to Lakeland where he was city physician for many years; was a veteran of World War I; held membership for 46 years in the Florida Medical Association and was a member of the American Medical Association; died January 25, aged 85.

O'Neill, John Brooks, St. Petersburg; born in Boston, Mass., on Dec. 9, 1893; University of Virginia School of Medicine, Charlottesville, Va., 1918; served an internship at Royal Victoria Hospital, Montreal, Que., Canada, and residencies in the United States Naval Hospital, Washington, D. C., and various other Naval hospitals; practiced internal medicine in the United States Navy from 1918 to 1947, retiring with the rank of rear admiral; was chief medical officer at Paris Island Marine Base in 1939 and 1940 and also served with the Marine Corps in Haiti, China and Nicaragua; practiced 12 years in St. Petersburg; held membership in the American Medical Association; died Dec. 4, 1963, aged 71.

Robinson, Julian, Miami; born in Bucharest, Romania, on Jan. 11, 1881; New York Homeopathic College, New York City, 1921; served an internship at New York Homeopathic Hospital and engaged in other postgraduate work at Algemine Krankes Hospital, Vienna, Austria; practiced general medicine and gynecology in Brooklyn, N. Y., for 26 years and from 1921 to 1927 served as Romanian consul general there; moved to Miami in 1946 and continued practice there until illness forced his retirement in 1961; was a veteran of World Wars I and II; was a fellow of the American Medical Association, a member of the American Geriatrics Society and an honorary member of the International Academy of Medicine; died Dec. 6, 1963, aged 82.

Shackelford, Walter Lawson, West Palm Beach; born in Meridian, Miss., on July 8, 1896; University of Pennsylvania School of Medicine, Philadelphia, 1921; served an internship at Touro Infirmary, New Orleans, La., and residencies at South Mississippi Charity Hospital, Laurel, Miss., and Good Samaritan Hospital, West Palm Beach; had engaged in the general practice of medicine and surgery in West Palm Beach since 1926; was a veteran of both World Wars; was a past president of the Palm Beach County Medical Society and of the Southeastern Hospital Conference; held membership in the American Medical Association, Southern Medical Association, American Academy of General Practice, American Hospital Association, American College of Hospital Administrators and Florida Association of Industrial and Railway Surgeons; died January 14, aged 67.

Stovall, Rupert Hope, Fort Lauderdale; born in Vienna, Ga., on July 16, 1881; New York University College of Medicine, New York City, 1905; served an internship at St. Vincent's Hospital in New York City and later pursued other graduate work at Harvard Medical School; engaged in the practice of general medicine in Vienna from 1905 to 1911, in Macon, Ga., from 1911 to 1925 and in Fort Lauderdale from 1925 to 1956; was a veteran of World War I; was county physician for Broward County from 1943 to 1957; was a past president and secretary of the Broward County Medical Association and also of the Third District in the Georgia Medical Association; was a member of the American Medical Association; died January 14 after a long illness, aged 82.

Wood, George Oviatt, St. Petersburg; born in Campbellville, Ky., in 1913; Vanderbilt University School of Medicine, Nashville, Tenn., 1938; served an internship in surgery at New York Hospital, Cornell Medical Center; assisted Dr. Alfred Blalock in research for one year at the Johns Hopkins University School of Medicine, Baltimore; went to the Mayo Clinic, Rochester, Minn., on a fellowship in surgery and later became first assistant in chest surgery at that institution; spent two years during World War II as a captain in the U.S. Army Medical Corps serving in the China-Burma-India theatre; entered the practice of surgery in St. Petersburg in 1952; was a diplomate of the American Board of Surgery and of the International College of Surgeons, a fellow of the American College of Surgeons, a senior fellow of the Southeastern Surgical Congress, a certified fellow of the International College of Surgeons, and a member of the American Medical Association; died Dec. 16, 1963, aged 50.



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New Members

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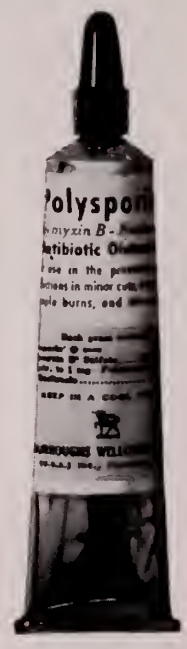
Active

Adams, Arland A., Melbourne
Ashburn, Llewellyn L., Tampa
Ballentine, Charles N., Fort Walton Beach
Bowling, Edward C. Jr., Brooksville
Bullwinkel, Bob, Ormond Beach
Burke, Sean K., Tampa
Carney, Robert T., Tallahassee
Chandler, William C., Dade City
Clark, Richard B., Pensacola.
Covell, William A., Pensacola
Giovinco, Joseph, Tampa
Hubbard, William H., Port Richey
Hunt, Owen R. Jr., Branford
Hux, Robert H., Leesburg
Kane, Wilton R., Live Oak
McDonald, William, Quincy
Matrin, Gilbert A. Jr., Daytona Beach
Patterson, Joseph R., Tampa
Schwenker, Carl E. Jr., Daytona Beach
Taylor, Donald W., Tampa
Truly, Harry L. Jr., Tampa

Associate

Ainsworth, William N. III, Jacksonville
Bennett, Jean L., Clearwater
Bodiford, Homer A. Jr., Orlando
Calman, Carl H. D., Clearwater
Campbell, Arthur S., Miami Springs
Canton, John N., St. Petersburg
Cestaric, Edward S., Gainesville
Christ, George H., Clearwater
Culbert, James E., Orlando
D'Adesky, Raymond G., Fort Lauderdale
Diaz-Silveira, Carlos F., Miami
Entel, Irwin L., Dunedin
Fipp, George J., Jacksonville
Godbold, Wayne L., Winter Garden
Goldstein, Alvin P., Miami
Harper, John M., Miami
Harvey, Edward R., Fort Lauderdale
Hecht, Howard L., Jacksonville
Hill, Gordon E., Fort Lauderdale
Ira, Gordon H. Jr., Jacksonville
Karrer, Max C., Jacksonville
McKenzie, Doris, Miami
McMillen, Robert E., Orlando
Moore, Jerry D., Fort Lauderdale
Nunn, Daniel B., Jacksonville
Panos, Theodore G., Jacksonville
Pepus, Martin, Miami Beach
Schwalbe, Frank C. Jr., Jacksonville
Strike, Thomas C., St. Petersburg
Wadlund, Robert R., West Palm Beach
Wallace, William E., Sarasota
Walton, William R., St. Petersburg

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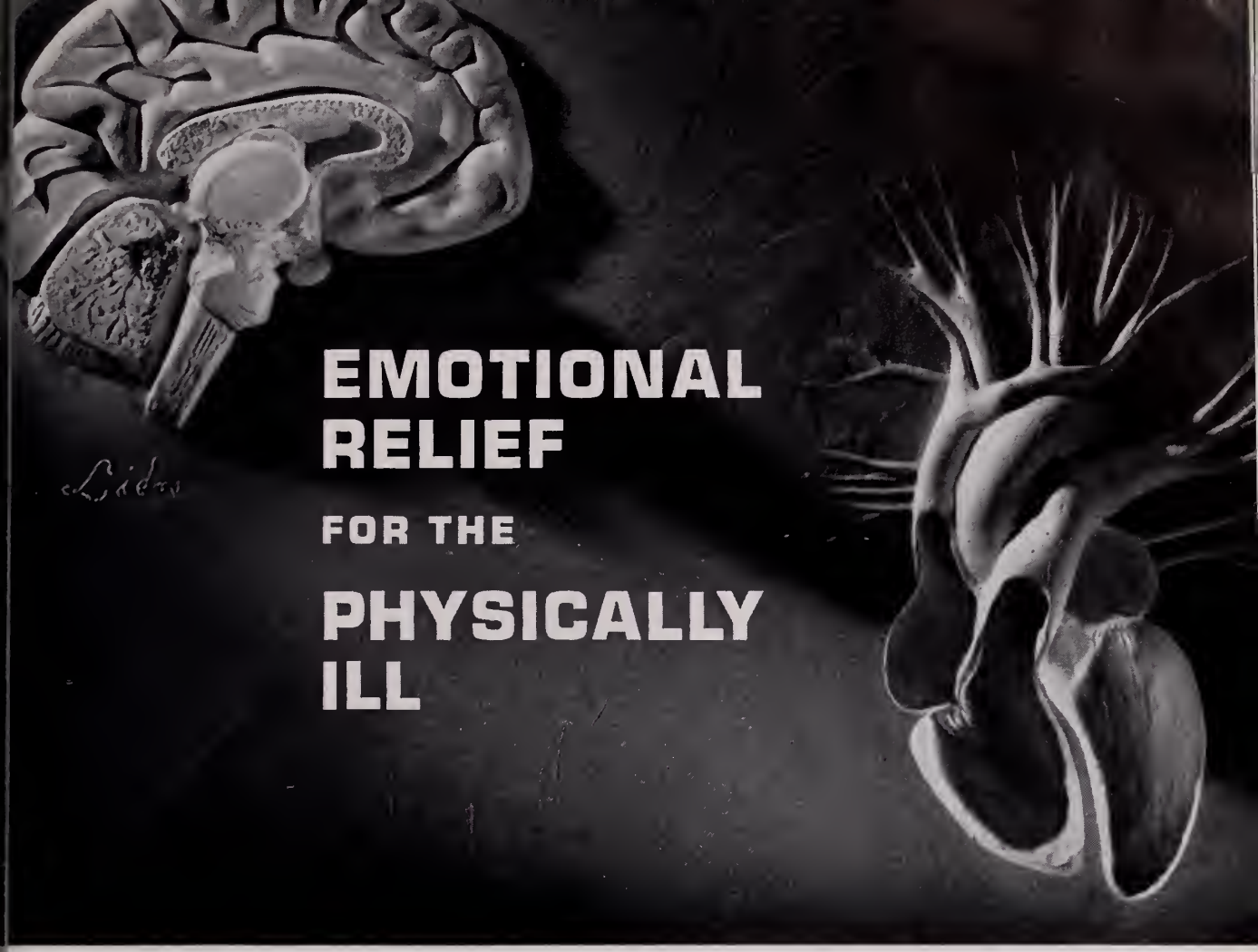
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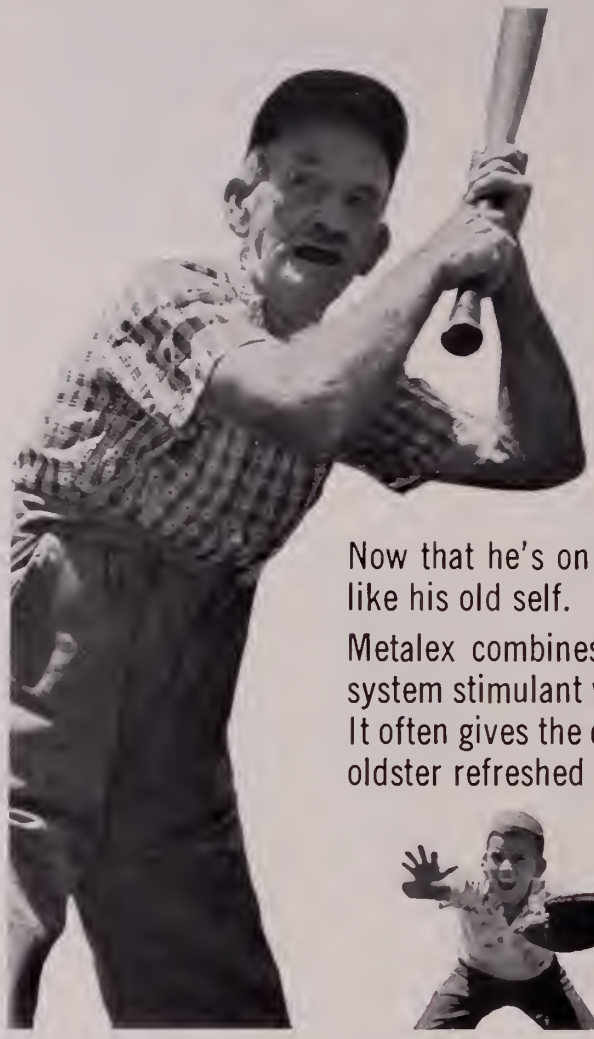
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382 Schenck Avenue, Brooklyn 7, N. Y.

[1] Simon, F. & Bernstein A.: "The Treatment of Obesity in Patients with Cardiovascular Disease," Angiology, *12*:32-37, Jan. 1961.
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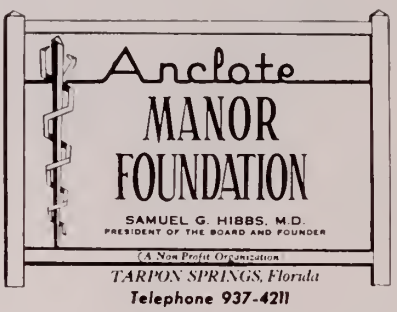
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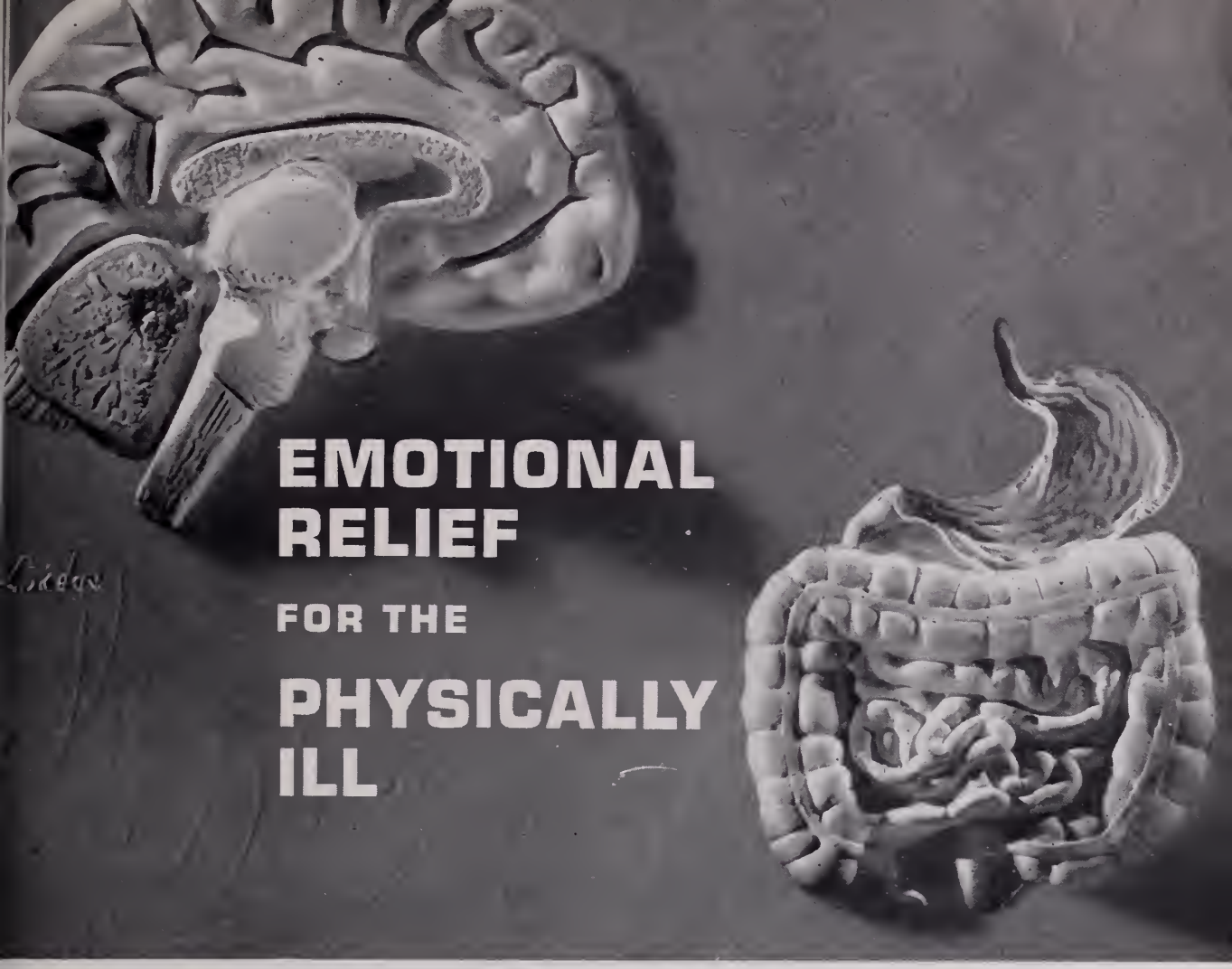
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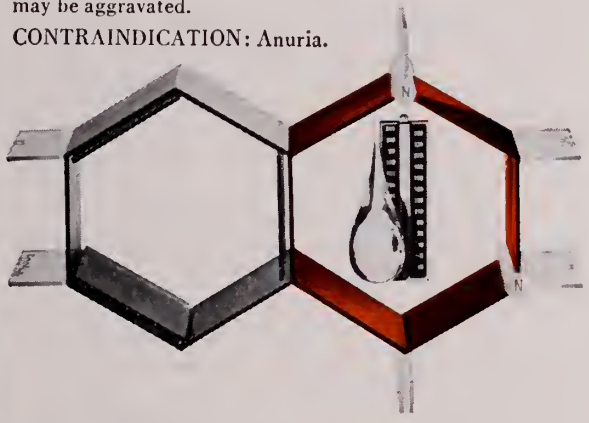
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CONTRAINDICATION: Anuria.



1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.
2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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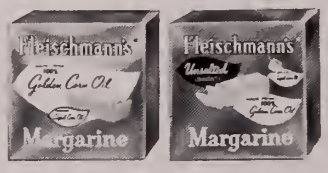
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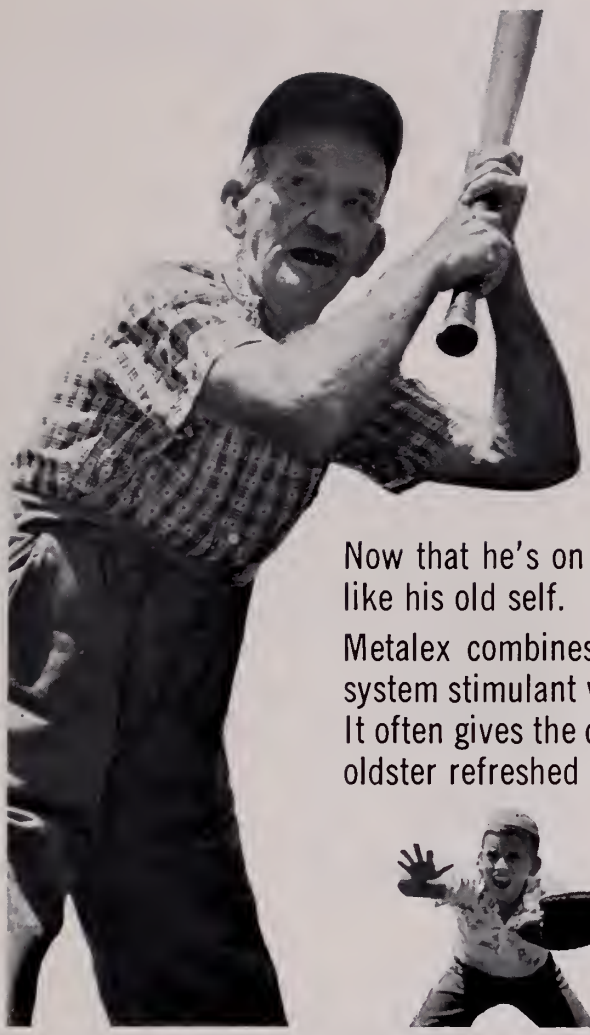
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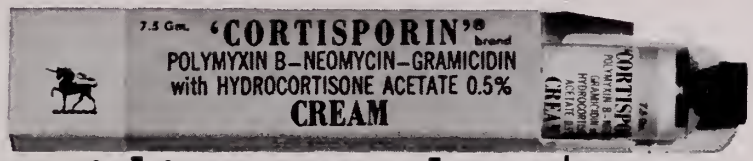
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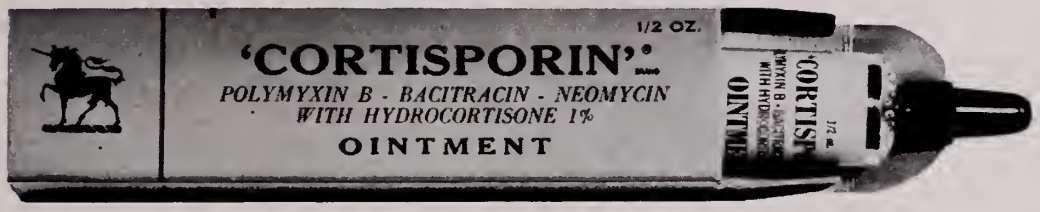
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The JOURNAL
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Fat Embolism

Wallace E. Miller, M.D.*
and Walter C. Jones III, M.D.**
MIAMI

Fat embolism is one of the complications of fractures. The Dade County Medical Examiner's office stated that between 80 and 90 per cent of all fatal cases of acute traumatic fractures will show fat emboli. It is our experience on the Orthopaedic Service of the University of Miami School of Medicine at Jackson Memorial Hospital that the patients who die as a direct result of massive fat emboli are very few. Patients who have a fracture of a major long bone, such as a femur or tibia, are usually the ones in whom fat embolism may occur. Symptoms do not develop immediately and there may be a relatively "free interval" from 30 minutes to nine days before a changing clinical state is manifested. The average time is 24 to 36 hours. The clinical picture varies, but usually both respiratory and central nervous systems are affected. The temperature is generally elevated (101 to 103F.).

Symptoms

I. Pulmonary symptoms may be manifested by:

- Increase in respirations up to 50 per minute
- Dyspnea
- Cyanosis of the lips and nail beds
- Cough
- Frothy or bloody sputum
- Pulmonary edema
- Bronchial pneumonia which may lead to cor pulmonale. Right-sided heart failure is due to the increased output necessary.

II. Cerebral symptoms may be manifested by:

- Insomnia
- Irritability
- Disorientation
- Coma or stupor
- Convulsions
- Rigidity (decerebrate or posturing)
- Occasional localized central nervous system signs

The appearance of the patient is one of distress. The cerebral signs and symptoms are sometimes confused with cerebral contusion and epidural hematoma. Although the patient may appear to be in shock, it is not unusual to find that the blood pressure is not as depressed as one might expect from the clinical appearance. The pulse is rapid (120 to 180) in fat embolism and variable or slow in the other two conditions. The respiratory rate usually follows the pulse rate in these conditions also. An electroencephalogram shows a diffuse slow wave disturbance in fat embolism as another point of differentiation. The temperature may be increased for several days and then return to normal. Two or three days after initial symptoms develop, skin changes are often seen in the form of a fine petechial rash that appears over the upper part of the trunk, especially in the axillae and over the lateral aspect of the chest. Petechiae may appear in the conjunctiva of the lower lids also. These disappear after a few days.

Examination of the blood, urine and sputum and radiographic views of the chest aid one in the diagnosis of this entity. Scuderi[1] used the technique of darkfield examination of the blood. Peltier[2] used a water-soluble fluorochrome dye in blood and then observed the contrasting fat globules under fluorescent microscopy. The re-

From the Orthopaedic Surgery Service of the University of Miami School of Medicine, Jackson Memorial Hospital, Miami.
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sults of these tests are not very rewarding clinically, for normally blood has about 0.4 per cent total lipoid content. Schneider[3] concluded that fat droplets in the blood have little value per se as the size of the globules is of much more importance than the total number comprising the quantity of blood fat. When fat emboli are present, the lipoid globules measure 4 to 20 microns in diameter.

Peltier[2] and others have noted a precipitous drop in the hemoglobin level coincident with the onset of early findings such as dyspnea, disorientation, and petechial hemorrhages. This is not constant and is probably due to loss of blood into the tissues or hemolysis.

Blood lipase is frequently elevated in association with fat embolism. Schuttemeyer and Flach[4] reported on 95 patients with fresh fractures or operations on the bone. In 57 elevated serum lipase reached its peak two hours after injury and returned to normal within 24 hours. Of the 11 patients with the highest elevation of the serum lipase, seven died. Titze and Friess[5] reported on 471 patients with fractures. In 116 patients the serum lipase was elevated and in 57 of these it was markedly so. An elevated serum lipase value reflects an increased production of pulmonary lipase hydrolyzing neutral fat into fatty acids and glycerol. Serum lipase values higher than 2 cc. indicate that circulation through the lung is maintained.

Fat globules may be demonstrable in the sputum, usually, after 36 hours. This test gives positive results so frequently in the absence of fat embolism as to make it unreliable. Fat in the sputum may be demonstrable in other diseases, too.

Musselman[6] and others accepted the demonstration of free fat in the urine as a practical confirmatory test for fat embolism, although it will falsely include and exclude some patients. Morton[7] studied 52 orthopaedic patients who had fairly extensive injuries to various bones. It was concluded that fat was demonstrable in the urine of 41 of these patients. None, however, showed a definite clinical picture of fat embolism, and Morton[7] concluded that the correlation of the tests was poor and not a valuable diagnostic aid. Scuderi's methods[1] for examination of the urine for fat are perhaps the best:

(1) 'Sizzle test' is performed when a drop of top layer urine is removed with a platinum wire loop and put into a Bunsen flame. Sizzling or popping if fat is present even up to dilutions of 1:1600.

(2) Scuderi's Sudan III method: "The patient must completely empty the bladder because any fat will be found floating on the top layer of urine in the bladder; this urine is the last to be voided. The urine to be examined must be taken from the top layer of the specimen, for the same reason. The Sudan III stain must be fresh and highly concentrated and should be allowed to act for at least five minutes. The staining should be done after a drop of urine has been transferred to a slide, not in the test tube. Finally, any globules taking the stain which are less than three to four microns in diameter are to be regarded as contaminants or undissolved particles of stain."

A review of the literature as to diagnostic laboratory tests for this condition makes it evident that at present there is no satisfactory definitive test for fat embolism. Fat in the sputum and urine is not pathognomonic though it may be presumptive. Serum lipase studies, when further developed, may be helpful. Radiological examination of the chest is of doubtful value.

Treatment

The treatment of fat embolism is neither specific nor empirical, and many features used in the usual management of fractures tend to diminish the danger of fatal fat embolism. The best treatment is preventive, through correct splinting, careful transportation, early definitive reduction and immobilization of fractures. One must handle the patient carefully.

Use of the pneumatic tourniquet during all elective operations on the bones of the extremities may decrease the amount of fat reaching the lungs of the patient. Elevation of the injured limb may also be of benefit in decreasing the amount of fat reaching the general circulation. Another preventive measure has been the generally accepted waiting period between major operative procedures: this has been stated as a specific five day waiting period in most instances.

Oxygen is advised, and in many instances it has been given as positive pressure oxygen with good results. Since anemia is a major factor, blood transfusions are utilized. Intravenous fluids, given up to 2 liters per 24 hours, will also help to avoid circulatory collapse.

The aspect of variability of treatment comes in the more specific agent that is being used and since there are different ideas as to the etiology, naturally the specific agents vary directly to those ideas. One technique is to mobilize lipase formation (Hillman-Cobb use[8] of heparin); another technique is to inhibit lipase activity (Hermann, Pipkin and Peltier's use[9] of alcohol as the best type of inhibitor); still another technique has been used by one of us (W.E.M.), with good results, involving a so-called emulsifying agent (calcium gluconate); and finally one other approach continues to be the use of ACTH on the assumption that the fat embolism is merely an expression of a generalized alarm reaction. A recent report suggests the use of an agent to decrease the diameter of the fat globules (Saunders[10] used Decholin). All of these agents are used empirically at present and no one of them is recommended over the other, although at the present time heparin and alcohol are the two most favored in use in America.

A somewhat more specific outline of use follows:

1. Heparin—Subcutaneous administration, 5,000 units every six hours in adults; no clotting time above five minutes on this regimen. Lipase activity is checked and varies from 1.0 cc. (0.05 N N_2OH) lipase activity to five or ten times the amount by the second or third day. A high serum lipase activity level, above 2.0 cc., indicates a good prognosis.
2. Alcohol—Intravenous administration, 1,000 cc. of 5 per cent alcohol in 5 per cent glucose (500 cc. if a woman, and 1,000 cc. if a man) every 12 hours until three injections have been given. Oral administration is 1 oz. of 100 proof whiskey every four hours for five days.
3. Calcium Gluconate—Intravenous administration of 5 Gm. per day (one ampoule has 1 Gm.). This can be given up to 15 Gm. per day if necessary although 5 Gm. is probably enough. It is given in a slow drip of 5 per cent glucose solution.
4. ACTH—Intravenous administration of 20 units of corticotropin in 500 cc. of 5 per cent glucose solution in a slow drip every eight hours, gradually reduced to five units per instillation as the patient improves.
5. Decholin—Intravenous administration of 5 cc. of a 20 per cent solution (Decholin IV) every five hours until no Sudan straining fat is demonstrable in the last drops of urine. Sometimes up to 200-300 cc. needs to be injected. Nausea, vomiting and transitory jaundice are side effects. It is contraindicated in patients with biliary obstruction or acute hepatitis.

At the present time all methods that are empirical are continuing to be investigated and used at the University of Miami School of Medicine at Jackson Memorial Hospital. No one method has been found to be superior over another.

References are available from the authors upon request.

1000 Northwest Seventeenth St. (Dr. Miller)
3634 Bayview Road (Dr. Jones).

The Neurosurgical Alleviation of Pain in Cancer

Hubert A. Aronson, M.D.
Miami

From the days of Ambroise Paré in 1598 to the present time, surgical alleviation of pain has been successfully utilized. It was not, however, until the modern era of neurosurgery began, at the turn of the century, that an orderly physiologic approach to control of pain was established. S. Weir Mitchell in 1872 remarked, "Few persons can realize the influence which long, continued, unendurable pain can have upon both body and mind." With cancer patients now surviving for longer periods, more and more patients are faced with the prospect of a painful termination of their illness. With the full realization that pain, as a symptom, can be totally demoralizing and destructive of a personality, neurosurgeons have endeavored to control successfully pain secondary to cancer.

Assistant Professor of Neurosurgery, University of Miami School of Medicine.

It must be understood that surgical control of pain in no way will biologically affect the patients' basic underlying disease. The contemplated procedure is performed only for the symptomatic relief of pain and its associated unpleasantness.

Patients are candidates for surgical control of pain when they have met certain criteria: (1) A life expectancy of at least two to three months. (2) Pain not controlled by analgesics of the strength of codeine. (3) All surgical procedures on the basic tumor have been accomplished. (4) Other procedures such as x-ray and chemotherapy have been found valueless for controlling the pain. On the basis of these criteria, a large number of patients could profit by surgical control of pain.

Tumors of the Head and Neck

Tumors of the head and neck provide the neurosurgeon with a great challenge because they generally invade structures and produce pain in the fields of distribution of many nerves. With tumors of the sinuses, alveolar ridges, and face, that is, tumors producing pain in the distribution of the trigeminal nerve, several avenues of approach are open. If a lesion is quite peripheral, blocks of the roots of the trigeminal nerve can be accomplished with alcohol. For tumors involving the nerve more proximally, extradural section of the nerve in the middle fossa can be accomplished. Most patients, however, have pain in more than a single division of this nerve or involvement of more than the trigeminal nerve alone. In such cases, surgical judgment is needed to decide upon the procedure of choice. Surgical measures might include, in addition to section of the trigeminal nerve, section of the glossopharyngeal nerve, posterior rhizotomy of the upper cervical nerves and trigeminal tractotomy. The use of one or a combination of these procedures generally provides satisfactory relief of pain in the great majority of patients. Mortality in these various procedures is low. Morbidity consists of anesthesia of the cornea, in peripheral nerve sections, with the possibility of ataxia and weakness in tractotomies.

Pain in the Trunk and Extremities

The treatment of pain of the trunk and extremities is a somewhat easier problem. Peripheral neurectomies generally are useless. Patients suffering from localized areas of pain in the trunk can be relieved by unilateral posterior rhizotomy as long as the rhizotomy covers at least one and preferably two roots above and below the level of the pain. Morbidity and mortality are low from this procedure and gratifying results are high. Because rhizotomy denervates all sensory modalities, it cannot satisfactorily be used in pain of the arms or legs. By far the most satisfactory form of relief has been found with anterolateral cordotomy. In those patients who have pain below the level of D-8, a cordotomy at the D-2 level has been satisfactory. For patients with pain in the upper extremity or upper portion of the chest, a cordotomy at the level of C-2 is necessary. Unilateral cordotomy will successfully alleviate contralateral pain; however, many patients have masked pain, and pain on the ipsilateral side becomes prominent when the more intense contralateral pain is controlled. A significant number of patients with pelvic carcinoma, therefore, require bilateral cordotomy. The relief of pain can be satisfactory in as high as 80 to 90 per cent. Mortality is low from this procedure and morbidity consisting of weakness of the legs and disturbance of the bladder is generally temporary. Bilateral cordotomy, however, may result in permanent dysfunction of the bladder.

Patients who have severe perineal pain and pain of the sacral dermatomes can be satisfactorily relieved with the introduction of 95 per cent alcohol in the subarachnoid space. The patient must be properly positioned so that the alcohol will rise and affect the lower posterior roots. The careful use of this technique has resulted in profound sensory loss and complete relief of pain with minimal loss of power. Sphincter disturbance, however, can be distressingly high.

In exceptional circumstances the spinothalamic tract can be interrupted in the medulla and upper portion of the brain stem. This procedure, however, has a greater morbidity and mortality than cordotomy. Prefrontal lobotomy, first reported in 1946 for relief of pain, has a limited role. It should be a procedure saved for those with diffuse suffering or where other procedures have failed. Although mortality is low, the postoperative personality deterioration is severe and disabling.

The type of operation must be selected to provide the patient with the maximal relief of pain and the minimal morbidity. Satisfactory results can be expected in a high percentage of cases. Neurosurgical control of pain should not be withheld until the patient is moribund, but should be considered as soon as the pain becomes a troublesome burden. Control of pain early in the course of the disease can provide the cancer patient with a more pleasant if not a longer life.

1000 Northwest Seventeenth Street.

Keratoacanthoma of the Vermilion Border

A Report of Four Cases

RICHARD A. VINTON JR., M.D.
AND LEO H. WILSON JR., M.D.
SARASOTA

Keratoacanthoma is a tumor which greatly resembles squamous cell carcinoma. It is possibly of viral etiology[1] and usually can be distinguished clinically from squamous cell carcinoma by its characteristic appearance, rapid growth, benign course, failure to metastasize and tendency to undergo spontaneous involution.

Although keratoacanthoma of the skin is common, only rarely has its occurrence on the vermilion border been reported. These few cases are discussed by Silberberg[2] in her review of the literature on this subject. Recently, four patients with this condition were seen within a period of six months. Their cases are reported to direct attention to this important tumor of the lip which apparently occurs more frequently than previously recognized. It is hoped that preoperative awareness of this seemingly benign neoplasm will prevent unnecessarily radical forms of therapy.

Report of Cases

Case 1.—On Dec. 28, 1962, a 65 year old white woman of light complexion was first seen for treatment of a tumor located entirely on the vermilion border of her lower lip at the midline. The lesion was 1 cm. in diameter, slightly elevated, keratotic, firm and painful. No lymphadenopathy was noted. The patient stated that four weeks earlier a "fever blister" had appeared on the lower lip at the site where the tumor subsequently developed. The initial crusting persisted and rapid growth ensued during the 10 days prior to her first office visit. A tentative diagnosis of keratoacanthoma was made and a biopsy was performed. The report was as follows: "Microscopically, one sees a down-growth of squamous epithelium showing keratinization in the central portion with no marked activity of the peripheral borders. This tumor is associated with considerable inflammatory reaction of both chronic and subacute types. A number of hair follicles are seen. Diagnosis: Keratoacanthoma."

After the biopsy was performed, rapid enlargement with further weeping and crust formation delayed excision for approximately two months. By that time a definite crater had formed in the center of the lesion and extension of the tumor to the skin of the lip had occurred (fig. 1). Microscopic examination of the excised lesion confirmed that the tumor was a keratoacanthoma. It was described as follows: "This section contains an epithelial tumor composed of a central keratinous plug overlying markedly hyperkeratotic, acanthotic stratified squamous epithelium. There are numerous keratinous cyst formations. The base of the tumor is heavily infiltrated with both mononuclear and polymorphonuclear leukocytes."

Postoperatively, crusting and weeping developed at the site of excision. This condition resembled the inflammatory reaction frequently seen in labial herpes simplex infections. It abated in approximately two weeks.

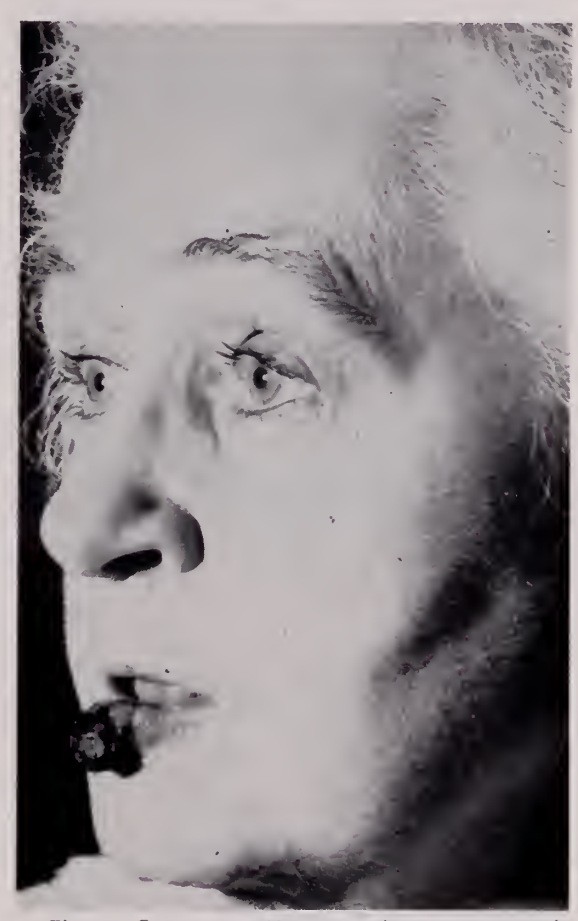


Fig. 1. Case 1. — Keratoacanthoma two months after biopsy. The lesion had extended to the skin of the lip.

There has been no recurrence of the lesion and neither new lesions nor metastases have occurred.

Case 2.—On Oct. 1, 1962, a 39 year old, red-haired bartender noted a "cold sore" in the center of the vermilion border of his lower lip. Approximately two weeks later the lesion was "pecked" by his pet parakeet, causing the lip to bleed. In a week he noticed a "growth" which persisted and enlarged. On Jan. 17, 1963, when he was first examined, a firm, slightly elevated, verrucoid, nonpainful tumor, 1.5 cm. in diameter, was present in the center of the lower lip. The lesion was confined to the vermilion border (fig. 2). No significant lymphadenopathy was noted. It was thought that the patient had a keratoacanthoma. In the operating room, a deep wedge specimen for biopsy was taken and examined by frozen section technique. This was reported as "keratoacanthoma" by the pathologist. The tumor was then completely excised with minimal margins of normal tissue at its periphery. Subsequent routine tissue examination confirmed the diagnosis. No postoperative recurrence, new lesion, or metastases have been noted.

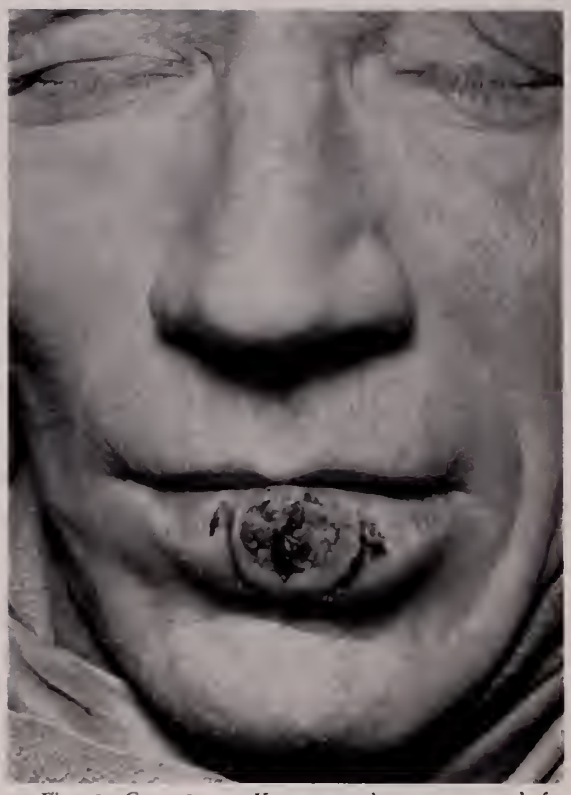


Fig. 2. Case 2. — Keratoacanthoma prepared for excision. A deep wedge specimen for biopsy had been taken from the lesion.

Case 3.—On May 4, 1963, a 21 year old white truck driver with a ruddy complexion was first examined in the office. Three distinct, crusted, keratotic, nonpainful lesions were noted on the left side of the vermilion border of the lower lip. The oldest and most lateral lesion was firm and elevated and had a central crater. The other two lesions were slightly elevated (fig. 3). The skin



Fig. 3. Case 3. — The lateral lesion was nodular and more elevated than the central ones.

of the lip was uninvolved. During October 1962 the patient had noted a "fever blister" on the left side of the vermilion border of the lower lip. The area became crusted and subsequently the firm nodular lesion developed. The medial lesions had been present for approximately six weeks. There was no lymphadenopathy. A biopsy was not performed since it appeared that the patient had multiple keratoacanthomas. These were excised conservatively and reported by the pathologist as "consistent with keratoacanthoma." There have been no new lesions, metastases or recurrence of the original lesions.

Case 4.—On June 15, 1963, a 46 year old white farmer with brown hair and fair complexion was first examined for a tumor of the lip. The lesion was oval-shaped, elevated about 0.3 cm., 0.5 cm. wide and 1 cm. in length. It was located entirely within the vermilion border of the lower lip at the midline (fig. 4). There



Fig. 4. Case 4. — Oval, crusted, slightly elevated keratoacanthoma. The vermilion border adjacent to the lesion was rough and scaly.

was no involvement of the skin of the lip. The lesion was nonpainful, "wart-like," and the vermilion border adjacent to it was scaly and rough. The tumor had been present for approximately one year and had grown appreciably several months before the patient sought medical attention. Although for years he had frequently had "fever blisters" on the lower lip, there was no history suggestive of a viral infection immediately preceding the appearance of the tumor. No lymphadenopathy was noted. A biopsy was not performed since it was thought that the patient had a keratoacanthoma. Conservative excision was performed and the specimen was submitted for microscopic examination. It was considered by the pathologist to be "consistent with keratoacanthoma." The tumor has not recurred and there have been no new lesions or metastases.

Comment

Keratoacanthoma was probably first described in 1889 by Hutchinson[3] in an article titled "The Crateriform Ulcer of the Face." Among its other synonyms are "self-healing primary squamous carcinoma,"[4] "benign keratoacanthoma,"[5] and "squamous cell pseudoepithelioma."[6] This tumor is important because it is often erroneously diagnosed as squamous cell carcinoma. Frequently, this error leads to excessive forms of therapy.

Classically, the untreated keratoacanthoma has three stages of development: (1) the proliferative stage, (2) the stationary stage, and (3) the involuting stage.[7] When first noted, the lesion is usually a small erythematous papule. Gradually it enlarges to become a firm, dome-shaped tumor with well defined borders. On the vermilion border, it may become moist and soft. Often there is a central crater which contains a crusted plug. At the completion of the proliferative stage, the tumor is usually 1 cm. to 2 cm. in diameter. During the stationary stage, there is little alteration in appearance and size. Involution usually occurs, resulting in a shallow atrophic scar. Each of the stages may last several weeks to several months.

Generally, one of two clinical patterns is found. Either a single lesion arises from an exposed area in a person over the age of 50 years or multiple lesions occur in younger persons. The latter pattern is very rare and sometimes familial. In these persons, the lesions may not involute spontaneously. When involvement of nonexposed areas occurs, the patients usually have multiple lesions. Although the face, ears, neck, forearms and dorsa of the hands are sites of predilection, lesions may occur anywhere on the skin. Nasal mucosa and buccal mucous membrane have also been involved.

Silberberg[2] found only 41 previously reported cases of keratoacanthoma of the lip. Since our four cases were seen in less than six months, we think that the condition is not as uncommon as the relatively small number of reported cases might indicate. Silberberg[2] stated that in none of the cases was a lesion described as being situated exclusively on the vermilion border; a small portion always extended onto the neighboring skin. When our patients were seen initially, each of their lesions was confined to the vermilion border. In one patient whose surgery was delayed, there was gradual extension of the lesion onto the skin of the lip.

The etiology of keratoacanthoma is unclear. Various factors possibly stimulate the neoplastic reaction. Most of the tumors occur on sun-exposed areas. They are found predominantly in Caucasians, especially those with light complexions and fair hair, but they are also seen in Orientals and Negroes.[8] Multiple lesions are sometimes observed in members of the same family. Workers exposed to petroleum products have an increased incidence of keratoacanthoma. Trauma may also be a predisposing factor. Using electron microscopy, Zelickson and Lynch[1] recently demonstrated intranuclear virus-like particles in a keratoacanthoma. It is noteworthy that three of our patients experienced "fever blister-like" lesions at the sites where keratoacanthomas subsequently developed.

The histogenesis of keratoacanthoma is disputed. Sebaceous glands, sweat glands and hair follicles have been proposed as sites of origin.[8] Most authors believe that the tumors arise from the pilosebaceous unit. When a lesion involves a mucous membrane, as was the case with our patients, it has been speculated that it arose from ectopic pilosebaceous elements or that it extended onto the mucous membrane from the skin.

The histopathology of keratoacanthoma and low grade squamous cell carcinoma can be so similar that it may be impossible to distinguish between them. This is mainly true during the proliferative and involuting stages. The diagnosis can often be made with confidence during the stationary stage, especially when a crater has formed. An accurate description of the lesion and a detailed history of its development are most helpful to the pathologist, especially when the microscopic findings are atypical. According to Lever,[7] a fully developed lesion shows in its center a large, irregularly shaped, keratin-filled crater. The epidermis extends like a "lip" or "buttress" over the sides of the crater. At the base of the crater, irregular proliferations of the epidermis extend upward as well as downward. Often an inflammatory infiltrate invades the lower border of the lesion (figs. 5-7).

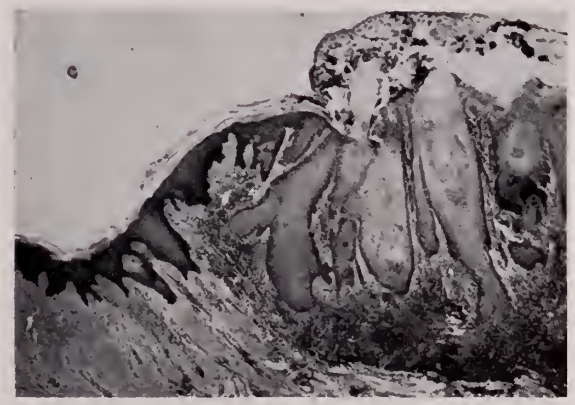


Fig. 5. Section of the tumor excised in case 4 shows an overhanging "lip" of epidermis, pseudoepitheliomatous hyperplasia, central keratinous plug and an inflammatory infiltrate in the neighboring dermis. Hematoxylin and eosin stain. X 35.



Fig. 6. Section of tumor excised in case 5 shows pseudoepitheliomatous hyperplasia, a well preserved basement membrane and the inflammatory infiltrate which invades the epidermis in some areas. Hematoxylin and eosin stain. X 100.

There have been reports of a few lesions which clinically resembled keratoacanthoma, but on microscopic examination were found to have histological evidence of malignant change. Also reported are several cases of squamous cell carcinoma with metastases which allegedly developed from keratoacanthomas. Baer and Kopf,[3] in their excellent review of keratoacanthoma, mentioned that Rook and Cronin recently reviewed the subject and concluded that there is not a single case on record of a keratoacanthoma in which malignant disease developed biologically, that is, with distant metastases, as distinct from histologically.

A correct pathological diagnosis should enable the physician to assure the patient that he does not have a carcinoma. Thus, the stigma of malignant disease is removed and the patient is relieved of needless fear and concern. Removal of this stigma may be important from another aspect, that of insurability. Perhaps patients with keratoacanthomas have been denied life or hospital insurance because their lesions had been misdiagnosed as squamous cell carcinoma of the lip.

Since keratoacanthomas almost invariably involute spontaneously, treatment of lesions on the vermilion border might seem unnecessary. On the contrary, there is convincing evidence to support conservative removal. First, clinical differentiation between squamous cell carcinoma and keratoacanthoma is not always possible. Second, some lesions have become several centimeters in diameter during the proliferative stage. Third, scars which follow spontaneous healing are often cosmetically unacceptable. Fourth, patients may insist upon treatment because of pain or unsightliness, especially when lesions persist for many months.

Excision, irradiation, curettage with subsequent electrodesiccation and partial "shaving" followed by electrodesiccation were the procedures used to treat the previously reported cases of keratoacanthoma of the vermilion border. There was no recurrence among the patients whose lesions were excised. Recurrences were noted, however, with the other modes of therapy.[2] By

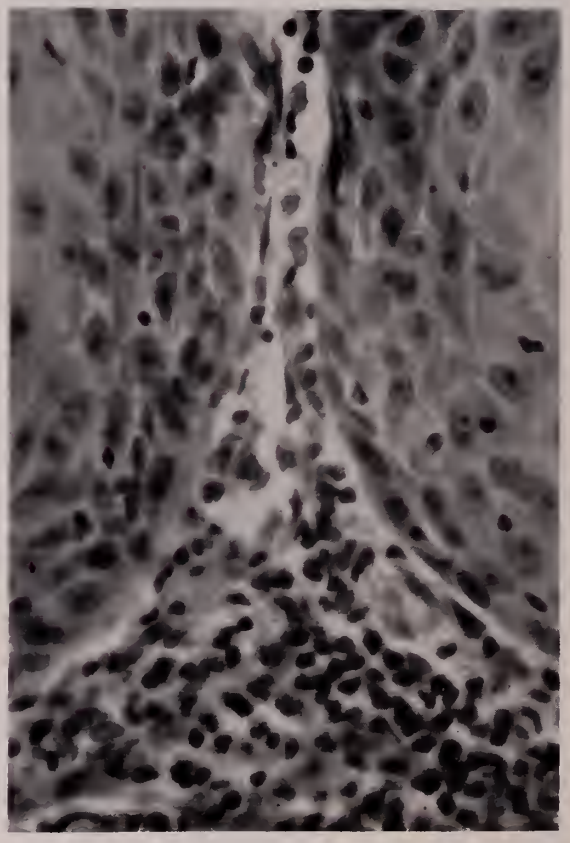


Fig. 7. An enlarged portion of figure 6 shows the intact basement membrane and invasion of the epidermis by the inflammatory cells. Hematoxylin and eosin stain. X 430.

contrast, all of the aforementioned procedures are highly successful in treating keratoacanthomas of the skin. In the management of keratoacanthoma of the vermilion border, we believe that only complete conservative excision combined with immediate repair has fulfilled the tenets of desirable treatment. This provides a suitable specimen for the pathologist, meets the patient's demand for early removal, produces a good cosmetic result, and yields a low recurrence rate.

When it is difficult to decide from the history and appearance of a lesion on the vermilion border whether it is a keratoacanthoma or a squamous cell carcinoma, we recommend a frozen section examination followed immediately by definitive excision. A routine biopsy may disseminate locally a possible viral agent and thereby stimulate cellular growth, inflammation, and enlargement of the tumor. Thus, definitive excision may be delayed. We think that this is probably what occurred in case 1.

Proper surgical technique varies according to the size and location of the lesion. For the solitary large lesion, a vertically directed, spindle-shaped excision should be made. This should incorporate the tumor and the full thickness of the vermilion border at the plane just superficial to the underlying muscle. Sometimes skin must be included in the excised tissue. A small lesion or multiple lesions are often best excised by the "lip shave" procedure utilizing the advancement of a mucosal flap in the repair.

Summary

Four cases of keratoacanthoma of the vermilion border are reported. The clinical features, etiology, histopathology and management of this tumor are discussed. It is thought that the condition is more common than previously recognized but often misdiagnosed. A plea for conservative surgery is made.

We are grateful to pathologists John S. Braken, M.D., William F. Mahoney, M.D., and Millard B. White, M.D., for the tissue examinations and to Mr. Henry J. Helmuth for the clinical photographs and photomicrographs.

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202 Doctors Gardens Building (Dr. Wilson).

Perforated Meckel's Diverticulum Due to Fish Bone

Report of Case

VICTOR DABBY, M.D.
CORAL GABLES

A case with an unusual complication, resulting from eating fish, is reported. The clinical findings simulated those of acute appendicitis. The operative findings stress the importance of adequate exploration.

Report of Case

A 50 year old white man was admitted June 2, 1963, to the Baptist Hospital of Miami because of abdominal pain of 24 hours' duration. The patient experienced onset of vague periumbilical distress followed by definite pain in the right lower quadrant of the abdomen. He complained of nausea and anorexia, but no vomiting. He had undergone three operations for duodenal ulcer. The first two were for perforation; in the third, a subtotal gastrectomy was performed.

On examination, the patient appeared in good physical condition; the temperature was 99 F. and the pulse rate was 82. Tenderness and marked rebound were present over McBurney's point. Palpation of the left lower quadrant revealed severe rebound in the right lower quadrant. There were no masses, no guarding and no rigidity; bowel sounds were hypoactive. The rectal examination gave negative results. The white blood cell count was 13,100 with basophils 1, eosinophils 6, stab forms 2, segmented forms 70, lymphocytes 20 and monocytes 1. Urinalysis gave negative results.

No scout films of the abdomen were taken. A diagnosis of acute appendicitis was made, and the patient was operated on shortly after admission, through a McBurney's incision. The appendix was slightly inflamed. Free purulent exudate throughout the peritoneal cavity was noted. The incision was enlarged and the exploration carried further. A large diverticulum arising from the antimesenteric border of the ileum, about 3 feet from

the ileocecal junction, was found. The base of the diverticulum was wide, measuring 2.5 cm. in diameter. In the center of the diverticulum, there was a small perforation through which partially extruded the sharp end of a 1 inch fish bone (figs. 1 and 2). The diverticulum was excised, the bowel repaired, and the appendix removed. The enlarged incision was more than adequate to cope with the pathologic condition. The pathologic specimen consisted of a portion of diverticulum measuring 4 by 2 by 2 cm. Extruding from the inner portion of the specimen was a 2.5 cm. plasticized-appearing fragment of material. The pathologic report was Meckel's diverticulum with foreign body (fish bone).



Fig. 1. — Note fish bone (arrow) protruding from the diverticulum.



Fig. 2. — Excised specimen showing fish bone protruding from the diverticulum.

Comment

The patient ate fish two days before the operation, but did not remember swallowing a bone. The presence of exudate in the peritoneal cavity frequently causes superficial serosal inflammation of the appendix or periappendicitis. This may lead the unwary surgeon with a low index of suspicion to blame the appendix, discontinue further exploration, remove the organ and close the abdomen, with subsequent disastrous results from progressive peritonitis. This is particularly dangerous because of the mobility of the diverticulum, and the ileum, resulting in a continuous free bathing of the peritoneal cavity with bacteria. The absence of omentum either because of previous surgery, as in this case, or as in young children, intensifies the problem, making a free perforation especially hazardous and often fatal. In children, the finding of mesenteric nodes may further complicate the picture and point to mesenteric adenitis or primary peritonitis.

Complications from Meckel's diverticulum are rare in adults. They include intestinal obstruction, hemorrhage, formation of fistula or cyst, intussusception, ulceration, diverticulitis, and perforation. Diverticulitis with perforation accounts for about 4 per cent of all complications. The search for a Meckel's diverticulum should be a routine practice whenever the appendix is found normal, or slightly inflamed.

Summary

A case of a perforated Meckel's diverticulum in an adult male, clinically simulating acute appendicitis, is described. Perforation was caused by a fish bone and resulted in peritonitis and periappendicitis. When the latter condition is met with at operation, complete exploration should be carried out to determine the etiology of the peritonitis. The surgeon should be mindful of the fact that periappendicitis is frequently a secondary rather than a primary disease of the appendix.

2506 Ponce De Leon Boulevard.

Juvenile Nasopharyngeal Angiofibroma

Report of a Case

WILLIAM F. SHIPMAN, M.D.
TALLAHASSEE

The case described serves as a reminder of the necessity for early vigorous treatment of juvenile nasopharyngeal angiofibroma. This perplexing tumor is histologically benign, yet clinically lethal when hemorrhage or erosion of adjacent structures takes place. Since it does not commonly cross his path, the physician may pass the symptoms off as allergy or sinusitis without performing a mirror or finger examination, or may even neglect referring the patient elsewhere. The otolaryngologist may miss it the same way or be lured into watchful waiting in the hope that it will regress with puberty.

This locally growing vascular tumor occurs usually in young males in the early teens with symptoms of nasal obstruction, recurrent epistaxis, purulent rhinorrhea, facial deformity and nasal speech. The incidence is roughly one in every 5,000 ear, nose, and throat hospital admissions.[1] Prognosis is good despite recurrences with over-all mortality of about 3 per cent.[2-5] Treatment reported in the literature has not been completely satisfactory, but has usually been along the lines of surgery, irradiation, and hormone therapy. This is my first private case, although two cases were seen in residency with resolution after irradiation and surgery. In this case the patient was seen, in order, by the family physician, myself, Dr. George T. Singleton of Gainesville, and Dr. William W. Montgomery of Boston. My appreciation goes to these gentlemen for filling in the interim details of their care.

Report of Case

A 12 year old boy was first seen by his family physician in December 1960, with a two month history of diminished hearing and nasal obstruction. Nose drops, decongestants and antibiotics were given. As the symptoms progressed, he was seen in January 1961 in my office. At that time a mirror examination showed a glistening, vascular non-adenoid-appearing mass filling the posterior nasopharyngeal wall and obliterating the right eustachian tube area. Biopsy at that time in the office produced much bleeding and a nonconclusive pathologic report. Under general anesthesia in the hospital later, the mass was evulsed off the posterior nasopharyngeal wall and bleeding was controlled with packing. Replacement of 500 cc. of blood was necessary. After a definite pathologic report, the site was irradiated with 3,000 r. One month later recurrence was noted, and over the next few months, the lesion increased in size. Dr. Singleton consented to take over treatment.

When Dr. Singleton examined the patient on September 11, a mass filled the nasopharynx, projected into the right nasal cavity and depressed the soft palate. On September 15, an exploration through a Caldwell-Luc type of approach for the old Denker operation showed involvement of the ethmoids, but no breakthrough into the antrum. At this time, a palatine window was used for removal of the mass, with cautery of the base of the lesion. The patient required three pints of blood. After one month, a recurrence was noted and at operation on December 8, the transpalatine approach was repeated under hypotensive anesthesia and cautery of the base carried out with replacement of two pints of blood. Two months later, in February 1962, recurrence was again noted. At intervals during the next three months, four injections of Silvasol, a sclerosing agent, were given at the base of the tumor.

By May, the tumor had again increased in size, and at the request of Dr. Singleton, Dr. Montgomery consented to evaluate and treat. On June 14, in Boston, the eighth procedure was carried out; the mass was resected, and radon seeds were inserted at the base. Four weeks later, the persistent tumor was again observed with more growth on the right side. The patient returned to Florida, and in August, androgenic therapy was begun and has continued for seven months. Despite inducement of puberty, the tumor persists and is increasing slowly in size. Intermittent nosebleeds have occurred since, but have not been serious. On March 28, 1963, the tumor was larger but less vascular. At present the consensus is to leave it alone, unless it becomes markedly enlarged and bleeds excessively, and hope that regression will soon occur. The boy is now participating in restrained general activity for his age.

Read before the Florida Society of Ophthalmology and Otolaryngology, Scientific Session on Otolaryngology, Hollywood, May 18, 1963.

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Association News



Samuel Mason Day Jr., M.D.
Eighty-Fourth President

Acceding to the presidency of the Florida Medical Association at the Annual Meeting in May, Dr. Samuel Mason Day Jr. of Jacksonville is continuing to serve the Association faithfully and well after filling the office of Secretary-Treasurer for more than a decade. Born in Nixburg, Ala., in 1914, Dr. Day received his elementary and academic training in his native state. He attended the public schools of Alexander City and in 1934 was awarded the Bachelor of Arts degree by the University of Alabama, Tuscaloosa. For his professional training he enrolled at Washington University School of Medicine, St. Louis, and in 1937 received the degree of Doctor of Medicine. Upon completion of internships at Union Memorial Hospital and University Hospital, Baltimore, he served residencies from 1940 to 1942 at Doctors Hospital in New York City and James Walker Hospital, Wilmington, N. C., and later pursued further postgraduate study at Doctors Hospital. In 1942 he entered the Medical Corps of the United States Army, attained the rank of major and served as chief of general surgery and assistant chief of the surgical service at the Army Regional Hospital at Camp Blanding prior to discharge from military duty in 1946.

Shortly after separation from the service, Dr. Day entered the private practice of general surgery in Jacksonville. An active member of the surgical staff of St. Vincent's, St. Luke's, Baptist Memorial, Hope Haven and Brewster hospitals and the Duval Medical Center, he was from 1957 to 1962 co-chief of the Surgical Service at St. Vincent's Hospital and in 1960-1961 was chief of staff. Currently he is director of intern and resident training at that institution.

In the Duval County Medical Society Dr. Day served as associate editor of its Bulletin, secretary, president in 1959 and chairman of the board of governors in 1962. In 1960 he was president of the Jacksonville chapter of the American College of Surgeons. The following year he was president of the Jacksonville Hospitals Educational Program and he is a former vice president of the Duval County Unit of the American Cancer Society.

In 1951 Dr. Day was elected Secretary-Treasurer of the Florida Medical Association. He filled that exacting post with distinction for 12 years, serving by reason of his office as an ex officio member of the Board of Governors and a member of its executive committee. In 1963 he became President-Elect.

A diplomate of the American Board of Surgery, Dr. Day is a fellow of the American College of Surgeons, Southern Surgical Association and Southeastern Surgical Congress. He holds membership in the Southern Medical Association, American Medical Association and World Medical Association.

Dr. Day is medical director of American Heritage Insurance Company and was for 12 years assistant treasurer of Blue Shield of Florida. He is a former member of the advisory committee to the Florida Crippled Children's Commission and the Florida Vocational Rehabilitation Program. He serves as a member of the board of directors of the Boys Home Association and the Children's Home Association.

A former trustee of the Jacksonville Art Museum, Dr. Day is a member of the Meninak Club, the Florida Yacht Club and the St. Johns Dinner Club. He holds membership in the Riverside Presbyterian Church.

Dr. Day and Mrs. Day, the former Hazel Margaret (Dolly) Chitty of Jacksonville, have three sons and a daughter.



Are Physicians First Class Citizens?

Nearly 200 years ago the Declaration of Independence was signed giving to the world a new nation. There were 56 signers, men from every walk of life including physicians, who were willing to sacrifice themselves and their time for the good of their fellow man. In that list there was only one registered politician.

Since that time physicians have gradually weaned themselves away from participating in the welfare of their communities and their country. It can be said, however, that they have worked hard and well to conquer diseases that have been and are a scourge to the individual citizen. Furthermore, by education and strict licensure of themselves they have raised the standards of the medical profession to a degree that surpasses that of any other nation.

While this work was progressing, the politicians increased both in numbers and importance and in many cases to the detriment of our country and our profession. We are now in the midst of another "free" election in which Florida has a senatorial candidate and the nation has a presidential candidate both advocating legislation inimical to the citizenry and to the progress of all medicine. They seek the votes of the people who are uneducated as to the advances made by the individual doctor and his profession. To combat this approach the Florida physician has only one weapon—FLAMPAC. FLAMPAC is the one organization the Florida doctor can turn to for help and it is to the collective and individual interest of all members of the medical profession to join and support this organization immediately.

FLAMPAC cannot function without money and the money necessarily must come from the doctors themselves. This money will be allocated by your own colleagues to educate the people as to those men and candidates who are known and are willing to be for the betterment of the citizens of each community, the state, and the nation.

Physicians must be at least part politicians in order to know best how to educate the voters. This role means that a certain portion of one's income must be used to see that the educational program is carried out. FLAMPAC is giving you the means of accomplishing this objective; so I beg of you to support FLAMPAC, which will support you.

Physicians are renowned for objecting to supporting or working for anything political, but the time is now here when we must either do so or succumb to the political maneuvering for votes. The least you can do is to stand behind FLAMPAC, giving much more than token support to help those of your colleagues who are giving their money, their time and themselves. Let us all return to our forefathers' creed of being not only physicians but also interested and loyal citizens.

Meredith Mallory, M.D.
Orlando

Stand Up and Be Counted

Now is the time to stand up and be counted. It is appalling how doctors of medicine have collectively been placed on the defensive. It seems we are constantly defending our fees, defending our treatments, the drugs we administer, and even the ethics we use to maintain our standards. We have been maneuvered by much of the press, so that it appears we are against compassion, old people, poor people, the labor movement, most government agencies, medical school grants, and the increase of medical students.

Seldom is the medical profession creative; normally, we are on the offensive only as an alternative to some previously offered proposal.

Doctors by necessity are scholarly. Their training calls for and demands judgment based on interpretation of known or obtainable facts; calls for and demands study logically integrated with previous experience, as well as the ability to recall pertinent histories. Thus, the conscientious utilization of all these facets to care for a patient makes for the noblest of medical traditions.

"Be noncontroversial," likewise, has been a medical tradition, but this is one we can no longer afford. Doctors, individually, and as a group, stand to be regulated even more—notice the word "more." At present, we are regulated by the Federal Narcotics Authority, the Veteran's Administration, the State Licensing and Workmen's Compensation Boards, city zoning laws, insurance companies setting our fees, not to mention hospitals' rules governing staff membership and privileges. Very recently, the Kefauver Committee launched a wholesale attack upon the pharmaceutical companies. Many of the findings were not interpreted in the best interest of medicine, and many of the proposed corrections are certainly debatable.

Have we become so specialized that our intelligence is applicable only in the science of medicine, or is it only by our own unthinking choice that we retire from our country's political growth? Too often we hear doctors make poor businessmen or poor politicians; the latter is sometimes proclaimed with pride, as if all politics is messy business, unworthy of a profession. Here it should be noted that law is a profession. Lawyers often serve our citizens in times of great need where life is in the balance, and so far, they are in no immediate danger of socialization.

How is the business of making our country great achieved? It is somewhat similar to our patient treatment; the interpretation of many diverse groups and individual citizens who take time to be concerned with the machinery of our country. To be sure, there are minority groups who strive for certain legislation, primarily for their own benefit. Labor is very effective in making known its wants. Is this dishonest? Certainly not. Is this good for the country? Perhaps so, perhaps not, but how much better if each of these groups or individuals is balanced off by opposite views. If all a candidate hears and sees is the liberal side, why is he not justified in believing there is no conservative side? If socialism is the only voice, can this candidate be expected to search out for the free enterprise voice. If all the money for his campaign can be accounted for on one side, is it not fair to believe this is the side that matters, and thus elects?

If we, as doctors, are unwilling to make campaign contributions, are unwilling to express our views, unwilling to attend political rallies to hear all sides, can we when others have been so active come to our elected officials and say, "Don't pass this law," or "Do pass this law," after all the other groundwork in the fine art of lawmaking has preceded it?

Florida has had two presidents of the American Medical Association in the past five years. No other state has been so honored in recent times; and make no mistake, the presidency of the AMA, among other things, is a political office.

At present, a governor's campaign is in fierce progress. To wage such a campaign takes money. The men vying for this office are all honorable men. They have held or do hold high legislative or executive posts in our state. Likewise, part of the cabinet is being elected; if not equal to the governor, these officials are still very important. These men cannot be bought. They have stated their philosophies; they hope they represent the majority as they see it. They can only do so if they are elected.

It is not suggested that doctors necessarily band together as a political movement, but, certainly as a bare minimum, let us examine the political creeds of the candidates, and where we find agreement with our own political creeds, make the candidate aware he is our choice. A labor leader speaks; he believes he represents the best interest of his union, and his words carry weight because of the number. Is it wrong for a doctor to speak out for what he thinks is best for his patients when the subject is medical care?

Stand up and be counted, or else suffer the consequence, and soon!

Laurent P. LaRoche, M.D.
Cocoa Beach

Automation and Individual Responsibility

The human spirit has never been in such danger of being extinguished as it is today, in this age of vicious gadgetry and mechanistic enterprise. People are subjected to conformity and mass appeal of communication media intent upon molding public taste. The subtle music of persuasion and subliminal stimulation are creating a nation of robots and "me-too-ers," in apathy, tension and confusion.

The machine is becoming the master of man and denigrating his noblest hopes. Man is losing confidence in himself and others. The terror of equality and the like terror of inequality cause frustrated groups callously to denounce those dedicated to democracy and freedom. Everything is suspect, including intellectualism, creativity, and brotherhood. What is not understood is feared and resented.

Individualism and the humanities are now anachronisms. The angry voices of the past 50 years are stilled. The historic few have occasionally influenced the pattern of gracious living. Our technological sciences try to subdue nature, yet the elements may destroy us.

The human brain is capable of imagination, truth and wonder. Man has always sought the initiative and challenge, adaptation to environment and successful pursuits for glory and renown.

Reflective man can preserve his sanity in the presence of massive machines if his "invincibility" is not too pretentious. The playful man laughs at his foibles and weaknesses. Machines, invented by man, still need men to supervise them. Machines become osbolete. Man, himself, will never become obsolete unless, through his own folly, he pushes panic buttons to oblivion or refuses retraining for new positions that arise in progress or change.

The battle of man and machines is nowhere more impressive than at Las Vegas, Nev. Men and women, intent upon successful gluttony, spend desperate hours and days working upon one-armed or two-armed "bandits." The human being slowly disintegrates into a golem, milking the machine for some futuristic bonanza. The hypnotic snare of the machine traps the avaricious. Automation can free man of much drudgery in his lifetime or make him a despairing slave imprisoned within himself.

Man, though periodically endangered, can still select and temper his inventive genius and gain salvation from the quicksands of mechanization. Man can make recreation and play a period of great beauty and repose. He must pursue the virtues and truths that will make him free. He must control violence and compulsions to achieve equilibrium and equanimity.

Too often, man seeks power and chicanery to outwit his fellows, to subdue and subject them to his will. Occasionally, he outdoes the machine in his own greed, setting himself up as a new god or an inquisitor.

The individual has the brain power and creative energy to adapt himself to modern technologies in science, medicine, and art. New methods constantly emerge from research and invention. The latest computers will never be able to reason and produce thoughts.

It is unfortunate that the emphasis today is upon quantity, not quality. Experts test capabilities by machines, for admission to jobs and universities. There is a massive trend to evaluate human virtues and talents with mechanical devices. The computers ignore important facets of heredity and experience. Modern educators surely are aware that no series of tests will ever effectively evaluate the total personality.

Colleges use slogans to enhance their prestige. Teachers must publish or perish. Great universities still value their scholars higher than computers and stimulate learning and research.

"Madison Avenue" skill has turned sanity into a morass of "jungle-heat" manipulation.

Modern man lives in a swiftly changing world. He curses these changes. His defenses are inadequate to deal with stormy vicissitudes. He becomes frustrated, rigid, and tense. He blames his neighbors, or foreigners, cursing his nemesis. The horror of nuclear weapons overwhelms him. The future annihilation haunts all mankind. How can man in the age of automation be preserved? Money, power, and property buy less and less of happiness.

Many humans regard life as worthless. The scientific community is aware of its responsibility to the human race. Weapons of destruction must not denigrate profound truths and human values. Suicide rates are mounting, especially in "civilized" countries. Machines in our culture are our

idealized gods. Personalities, too frail to handle increasing complexities of modern living, are becoming mentally ill. Politicians continue to cite favorable statistics, yet the majority live their lives in hopeless indignation and resignation. Each day is fraught with shocking emergencies.

Machines compete with man. Machines even turn out paintings by the thousands. A turn of the knob creates hundreds of designs that encourage mediocrity. Bigness and popularity invite fame and fortune. Mammoth plants of industry reduce men to ignoble cogs on the treadmill of despair. Too few workers have any concept of the over-all picture of their usefulness.

These lives have become boring and mechanistic. Caught up in the vortex of automation, they have lost the essentials and deeper meanings of their own lives, and have become unwilling pawns of sterility and monotony. Their children are mechanical dolls, molded efficiently, obeying authority with a protest, without imagination or curiosity. Is life really a farce of appearances and status symbols? Are we not all wearing masks of deception and intrigue? Who among us really believes he is honest with himself and others? What has happened to the Golden Rule, even among the religions of the world? The Brass Rule pontificates that automation will bring a utopia. The reflective individual knows that man must save himself by understanding his inner self and bestowing goodness and compassion on all mankind.

Automation is here to stay, and so is the individual. He must make his peace with automation and the technological advances. He must use his experiences to fulfill his greatest capacity. He must behold the wonders of science and evolution in a single biological cell.

The preservation of the individual in the age of automation depends greatly on his grasp of life's essentials. He must reshape his life to greater opportunities than acquisitiveness, lust of power, and bombastic revelry. He must hold dear the courage and resourcefulness of those heroic men who have brightened human history. The individual *will be preserved* for he carries within him the transcendent qualities that make him poet and king in a world that can be peaceful and benevolent.

It matters little that the machine can outperform man's work. The machine can never compete with man's reasoning and proliferation of Ideas in the search for the Infinite. Man's inner world will always remain the greatest enigma. Man's brain will always be the greatest secret of automation. The individual will preserve himself in any age of automation, for he will continue to face the future with an aggressive optimism, having the freedom, the zeal, and the determination that nothing can stop the forward advances of human progress toward the accomplishment of noble aims and higher excellence.

I. Leo Fishbein, M.D.
Miami Beach

Hearing Impairment in Children

An important step in the treatment of a child with hearing loss is recognition of the problem. The early diagnosis of a hearing disorder and its etiology is essential. Failure to recognize a hearing defect may have serious consequences for the child. He may be regarded as mentally retarded or emotionally disturbed. The deaf child cannot learn in a normal manner, and secondary emotional disturbances will result from frustration at not being able to understand or to be understood.

Pronounced hearing loss in children is not difficult to recognize, but mild or moderate hearing loss frequently remains undetected over a period of years. Almost invariably articulation is defective, and it is to be hoped that a teacher will note the speech defect and refer the child to a physician or a speech clinician. Responsibility rests on the parents, teachers, pediatrician, and family physician, both for the detection of hearing loss in children and for continued supervision of the entire treatment program for these children. Fortunately, approximately 80 per cent of the children with impairment of hearing have a conductive type of deafness amenable to medical or surgical treatment if detected early. Other causes of hearing loss in children are numerous, such as drug poisoning, toxic neuritis of the acoustic branch of the auditory nerve resulting from mumps or virus infections, and congenital defect in the middle ear, as well as psychological disturbances. If there is a question about the hearing acuity of a child, he should receive a complete ear, nose and throat examination with audiometric test in order to arrive at a definitive diagnosis.

Increased utilization of audiometric screening by individual physicians in combination with the school programs should permit detection of hearing impairment in the great majority of children. Thereby, early correction of the impairment may be successfully accomplished before any permanent damage has developed.

The most helpful measures for deaf children whose hearing cannot be restored by medical or surgical means are the use of a hearing aid, auditory training, instruction in lip reading, speech conservation and correction, and educational, vocational, and psychological guidance.

The parents of a deaf child also need help in solving his problems. A school or a speech therapist for the deaf child must be carefully selected, and parents should encourage the child to practice at home the speech that he has learned at school. Overprotection of the child must be avoided because it deprives him of opportunities for normal development, and his education is thereby delayed.

William Chew, M.D.
Leesburg

Others Are Saying

No Label

She was young, perhaps late twenties, dark hair, dark eyes, very pale skin. Really quite pretty, but in her coma, she looked almost dead. Still clutched in one hand, she had a prescription bottle —empty. Sig. 1 at bedtime for sleep. No label. What had she taken?

Dr. Barton is on vacation. Dr. Ludwig is covering. There is an urgent call for Dr. Ludwig to come to Mrs. Johnson's home. She has fainted. He finds her elderly, overweight, hypertensive, semi-comatose. Three prescriptions at her bedside, sigs. 1 in the morning, 1 at night, 1 qid. No labels. Dr. Ludwig can't possibly prescribe or use or know or recognize all of the thiazides, the rauwolfias, the sedatives, etc., on the market. Without labels he can make only educated guesses.

One of your own patients calls, at five minutes to twelve on a Wednesday. She thinks the medium size white tablets are making her nauseated. You have treated her for a dozen years and must have prescribed at least a dozen white tablets in that time. What is the name of the medication? Who knows! No label.

From life-saving problems to nuisance problems, in every case the physician would have been able to do a better job faster if the prescription had been labeled. Sure, he can find out what the prescription is with a simple call to the druggist. Five minutes if both lines are unbusy, or 10 hours if your call is 10:05 p.m. But even at five minutes, five times 12 is 60 and that is an hour in any man's life.

The old arguments against divulging the name of a prescription medication to the patient are passé. These arguments were never very good and now they are worthless. The average patient today is reasonably well read, well informed, and intelligent. Let's give him credit for that. And isn't that the patient we want, really? Granted there may be a rare case in which it might be better not to divulge the name of a prescription drug. Certainly such situations are extremely rare. In my experience I get much more intelligent cooperation from the patient if I take him into my confidence, tell him what medication I am prescribing, what reactions to expect, what side-reactions to watch for, and name the drug for him.

Then we come to the point of efficiency. We are all looking for ways to save time in the operation of busy practices. A minute or two can be saved several times a day if all prescriptions are labeled. Labeling also facilitates review of medications for patients on chronic dosages. The simple addition of a little box marked "label" along with the "refill" and "no refill" boxes to be checked precludes the necessity of writing anything—a quick check mark does the trick. I have also requested all druggists in the area to label all my prescriptions unless specifically asked to do otherwise.

After three years of such labeling I can think of no instance in which it appeared to be unwise or where it caused any difficulty. There have been hundreds of times, yea, thousands, in which it has facilitated the intelligent discussion of a patient's medications.

Karl R. Rolls, M.D.
The Bulletin
Sarasota County Medical Society
October 1963

X-rays of the Fingers That Point to the Diagnosis

Radiographic diagnosis of systemic disease is not infrequently suggested by findings noted in radiographs of the fingers. Illustrated here are four unrelated systemic diseases in which the diagnosis was suggested by the radiographs of the fingers.

Fig. 1.—A 52 year old man was admitted to the hospital because of fever and pain in the flank. He had a past history of pain involving several joints of the upper and lower extremities. The radiographic study showed evidence of gout, and the fever and pain in the flank were the result of a urinary calculus with infection of the urinary tract. Figure 1 shows the characteristic periarticular radiolucent defects produced by the tophaceous deposits of uric acid.



Figure 1



Figure 2

Fig. 2.—The radiographs of the fingers of a 42 year old man show subperiosteal resorption of bone along the shaft of the phalanges with considerable subperiosteal absorption of the distal phalanges. Such subperiosteal resorption of bone suggests the diagnosis of hyperparathyroidism and this radiological observation is considered pathognomonic of some disturbance in calcium metabolism. The patient had all the characteristic findings of primary hyperparathyroidism which was relieved by removal of a parathyroid adenoma.

Fig. 3.—A 52 year old Negro woman complained of loss in weight and difficult breathing. The radiograph of the chest showed extensive pulmonary fibrosis. The radiographs of the hand



Figure 3



Figure 4

showed the typical medullary and cortical changes which are occasionally seen in sarcoidosis and suggested the diagnosis of sarcoid. A biopsy of a nodule in the skin of the right thigh was interpreted as Boeck's sarcoid.

Fig. 4.—A 57 year old man entered the hospital because of arthritic pain in his knees and in the small joints of his hands. The radiographic examination of the fingers shows very faint periosteal new bone formation along the proximal phalanges, as well as broadening of the distal tufts. The soft tissues also show evidence of clubbing of the distal digits. An x-ray of the chest showed some widening of the superior mediastinum. The thoracic findings related to the changes in the finger would suggest a diagnosis of hypertrophic pulmonary osteoarthropathy in the fingers probably secondary to a malignant tumor involving the mediastinum. Scalene biopsy showed an undifferentiated squamous cell carcinoma, and autopsy at a later date demonstrated this was primary in the upper lobe of the left lung.

Raymond E. Parks, M.D.
Professor and Chairman
Department of Radiology
University of Miami School of Medicine
Coral Gables

Florida Radiological Society

Research at University of Florida College of Medicine

Department of Obstetrics and Gynecology

HARRY PRYSTOWSKY, M.D.
GAINESVILLE

The research program in this department encompasses diverse fields of investigation. At the present time the four primary areas of interest are: (1) the biochemical and endocrine aspects of reproduction; (2) the neuroendocrine control of ovulation; (3) microbiology of the female genital tract; and (4) physiologic studies related to reproduction.

BIOCHEMICAL AND ENDOCRINE ASPECTS OF REPRODUCTION (Dr. Kenneth McKerns).—The primary purpose of this unit is to learn how the sex hormones exert their unique effects. Attempts are being made to relate mechanisms of hormone action to inhibition or stimulation of specific enzyme systems that regulate oxidation-reduction states in the cell. The dynamic interrelations between the endocrine systems, such as the ovary and pituitary, are also being studied. An understanding of these processes will have significance in our appreciation of energy utilization, growth and differentiation, and in disease states. They will also add to our understanding of the cyclic hormonal processes in the menstrual cycle concerned with fertility and sterility, the regulation of milk secretion, and the hormonal role of the placenta. There are several interrelated research projects currently under investigation: (1) the mechanism of action of the regulation of the adrenal cortex; (2) hormonal regulation of the anterior pituitary; (3) control of estrogen and progesterone synthesis in the human placenta; (4) regulation of hormone synthesis in the corpus luteum of the human ovary; and (5) factors influencing contractility of the uterus at term.

NEUROENDOCRINE CONTROL OF OVULATION (Dr. Donald Christian).—It is clear that the central nervous system is intimately concerned with the control of ovulation through its influence of gonadotrophic release from the anterior lobe of the pituitary. To expand our knowledge of the mechanism of ovulation the following areas of research are being pursued: (1) the establishment of the central nervous system pathways involved, including the influences from the higher centers and exteroceptive stimuli which affect the basic controlling mechanism; (2) the effect of certain pharmacologic agents on the central nervous system control of ovulation; (3) the nature of the neurohumoral transmitter from the diencephalon to the anterior pituitary; (4) the manner in which luteinizing hormone triggers the ovary to follicle rupture and the temporal relations thereof; and (5) the biochemical events which occur in the ovary after circulating luteinizing hormone comes in contact with the ovary. Also currently under investigation is evaluation of the importance of the preoptic area of the diencephalon (functionally the hypothalamus) relative to the more posterior areas of the hypothalamus in the control of ovulation. The experiment is carried out in rabbits by stereotaxically implanted electrodes and electrical stimulation to the various areas under consideration with subsequent determination of ovulation histologically and histological determination of the point of stimulus to the central nervous system.

Professor and Chairman, Department of Obstetrics and Gynecology.

Microbiology of the Female Genital Tract (Dr. Richard Hildebrandt).—During the recent past we have been primarily concerned with microbiologic clinical problems as related to the obstetric and gynecologic patient. These studies have also dealt with the hazard or safety of various procedures accepted as rituals in obstetrics. For instance, it has been shown that there is a real danger in routine catheterization of the urinary bladder prior to delivery, and no deleterious effects have been noted by its omission. It has also been noted that a long term follow-up is necessary for a complete evaluation of the effects of bladder catheterization. The cervical flora and vaginal flora of pregnant women have been observed throughout the course of pregnancy, throughout labor and delivery and in the puerperium. We have observed the microbiologic effects of rectal versus vaginal examination in the parturient, of premature rupture of the membranes, and other factors. The microbial flora of the vagina and cervix presents as extensive and diversified a spectrum of pathogenic and nonpathogenic organisms as any other human tissue system. Specific host and/or environmental determinants of this microbiota remain obscure and in the main are not understood. Critical investigation is required for further understanding of the role and significance of microorganisms in obstetric and gynecologic patients.

Physiologic Studies Related to Reproduction (Dr. Vincent Stenger and Dr. Harry Prystowsky).—The current view that the mammalian fetus enjoys but a small margin of safety with respect to its oxygen supply appears to have its genesis in studies made in the early '30s. In the years that followed much of the relevant data accumulated served to strengthen the analogy with respect to the availability of oxygen in utero and at high altitude. The suggestion was clearly a fruitful one. Several lines of evidence all pointed, albeit indirectly, to a low permeability of the placental barrier as the factor responsible for the low oxygen tension in the fetal blood and to the inference that the fetus is adapted to a condition which it cannot regulate. But now there are other lines of evidence indicating that the fetus and its placental membranes are not impotent victims of their uterine environment; that, on the contrary, they exercise some degree of regulatory control over the rate at which oxygen diffuses from the maternal to the fetal blood. The mechanisms through which these regulations are operated remain to be described and provide ample scope for investigation.

Some questions to which we have directed our attention are: (1) What are the levels of pH, $BHCO_3$, and dissolved CO_2 in the maternal, fetal, and newborn plasmas under physiologically defined circumstances and how do changes induced in the maternal level of these variables reflect themselves in the acid base balance of the fetus and newborn? The same questions may be asked in regard to oxygen. (2) What are the oxygen, carbon dioxide, and hydrogen ion concentrations in the arterial and uterine venous bloods of pregnant women and what are the differences between the pregnant and nonpregnant uterus? (3) If a fetus carried by a mother at sea level is in effect living at simulated altitude, how does a fetus manage to survive that is borne by a mother whose systemic arterial blood pressure is reduced; whose pregnancy is complicated by toxemia or diabetes or anemia? What are the physiological and biochemical effects of such insults? What are the adaptive mechanisms that enable man to reproduce under such circumstances? (4) Finally, it has become increasingly clear that there is a real gap in our knowledge of the metabolism of the human uterus—pregnant and nonpregnant.

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Deaths

Harvard, Samuel Carnes, Brooksville; born in Arabi, Ga., on Jan. 6, 1902; the son of a local physician, Dr. Virgil O. Harvard; Emory University School of Medicine, Atlanta, Ga., 1930; served an internship at Grady Memorial Hospital, Atlanta, and a residency at its Steiner Clinic; since 1933 had engaged in the general practice of medicine in Brooksville; had a leading role in establishing and maintaining the present modern Hernando County Hospital; served as county physician and Atlantic Coast Line Railroad physician; served several terms as president and as vice president of the Pasco-Hernando-Citrus County Medical Society and for a number of years represented that society in the House of Delegates of the Florida Medical Association; held posts of high responsibility in the Florida Medical Association, including Chairman of the Council in 1957, First Vice President and Chairman of the Committee on Medical Economics in 1958, member of the Board of Governors since 1959, President-Elect in 1960 and President in 1961; was appointed to the State Board of Medical Examiners in 1958, serving as president in 1961; was also appointed by Governor Collins in 1959 to membership on the Florida Citizens Medical Committee on Health; served the Florida Obstetric and Gynecologic Society on several special committees and as president in 1957; also held membership in the American Medical Association and the Southern Medical Association; died April 7, in Jacksonville following a heart attack, aged 62.

Dickinson, Joshua Clifton, Tampa; born in Logan County, Ohio, on Jan. 29, 1885; Electic Medical College, Cincinnati, Ohio, 1907; after practicing for a year in Los Angeles, Calif., engaged in the general practice of medicine in Tampa from 1908 to 1920 and from 1920 to 1956, when he retired, limited his practice to radiology; was a past president and secretary of the Hillsborough County Medical Association; served as Chairman of the Section on Radiology of the Southern Medical Association in 1933; was a member of the Board of Chancellors of the American Board of Radiology from 1940 to 1950; was Chairman of the Section on Radiology of the American Medical Association in 1951; was a former Chairman of the Executive Council and in 1954 President of the American Roentgen Ray Society; in addition to holding life membership in all of these organizations which he served officially, was a charter and life member of the Florida Radiological Society, and a life member of the Florida Medical Association, American College of Radiology, and Radiological Society of North America; died January 9, of incarcerated hiatal hernia, aged 78.

Moore, John Norton, Ocala; born in Trenton, Tenn., on May 23, 1888; Vanderbilt University School of Medicine, Nashville, Tenn., 1919; interned at Jersey City Hospital, Jersey City, N. J., and served residencies in roentgenology at Bronxville Hospital and New York Hospital, New York City; engaged in the private practice of general medicine in Crawford, Tenn., from 1919 to 1924 and after special training had practiced general medicine and radiology in Ocala since 1926; was a past president of the Marion County Medical Society and a former president and secretary of the Florida Radiological Society; held membership in the American Medical Association, Radiological Society of North America and Florida Radiological Society, and was a fellow of the American College of Radiology; died March 1, aged 75.

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(Warning: May be habit forming)

Under the pressure of modern living, with its "small continued anxieties of life,"[6] functional disturbances of secretion, tone and motility of the gastrointestinal tract are extremely common.[6,8] For the relief of symptoms associated with such disturbances—through rest for the patient, rest for the colon[3]—the drugs of greatest value have proved to be the antispasmodics and the sedatives.[3,6,7]

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SIDE EFFECTS: No serious toxic reactions are to be expected. Dryness of the mouth, blurred vision, difficult urination, and flushing and dryness of the skin may occur with excessive and prolonged dosage.

PRECAUTIONS: Patients with incipient glaucoma or urinary bladder neck obstruction must be treated with care, as with any preparation containing a parasympathetic depressant.

CONTRAINDICATIONS: DONNATAL is contraindicated in acute glaucoma, advanced hepatic or renal disease, and known or suspected idiosyncrasy to any of its components.

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News

The Second Hawaii Medical Seminar is being held in Honolulu, June 26-July 1, 1964. There will be four days of scientific sessions in Honolulu followed by a 5 day workshop program on the neighbor islands of Kauai, Maui and Hawaii. The program is made up of distinguished guest speakers from the mainland and members of the Hawaii Medical Association. For further information details can be obtained from Hawaii Medical Seminar, Suite 300, 1612 K St., Washington, D. C. 20006.

Program plans for the Eighteenth Annual Rocky Mountain Cancer Conference in Denver, July 10 - 11, have been finalized and will include participation by the presidents of the American Medical Association and of the American Cancer Society. The popular two day conference in the city's Brown Palace Hotel will feature a symposium on "Etiologic Agents of Cancer, Their Avoidance or Prevention" on the first morning followed by an afternoon of scientific papers delivered by some of the nation's foremost physicians. The second morning of the conference will be devoted to a symposium on "Treatment of Cancer" with an "Information Please" session in the afternoon. Norman A. Welch, M.D., who will become president of the American Medical Association in late June, will participate in the conference.

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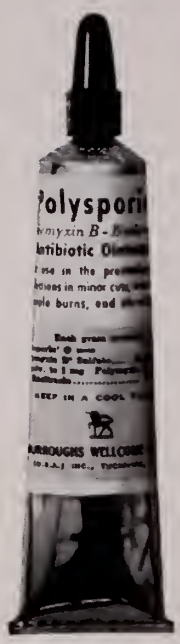
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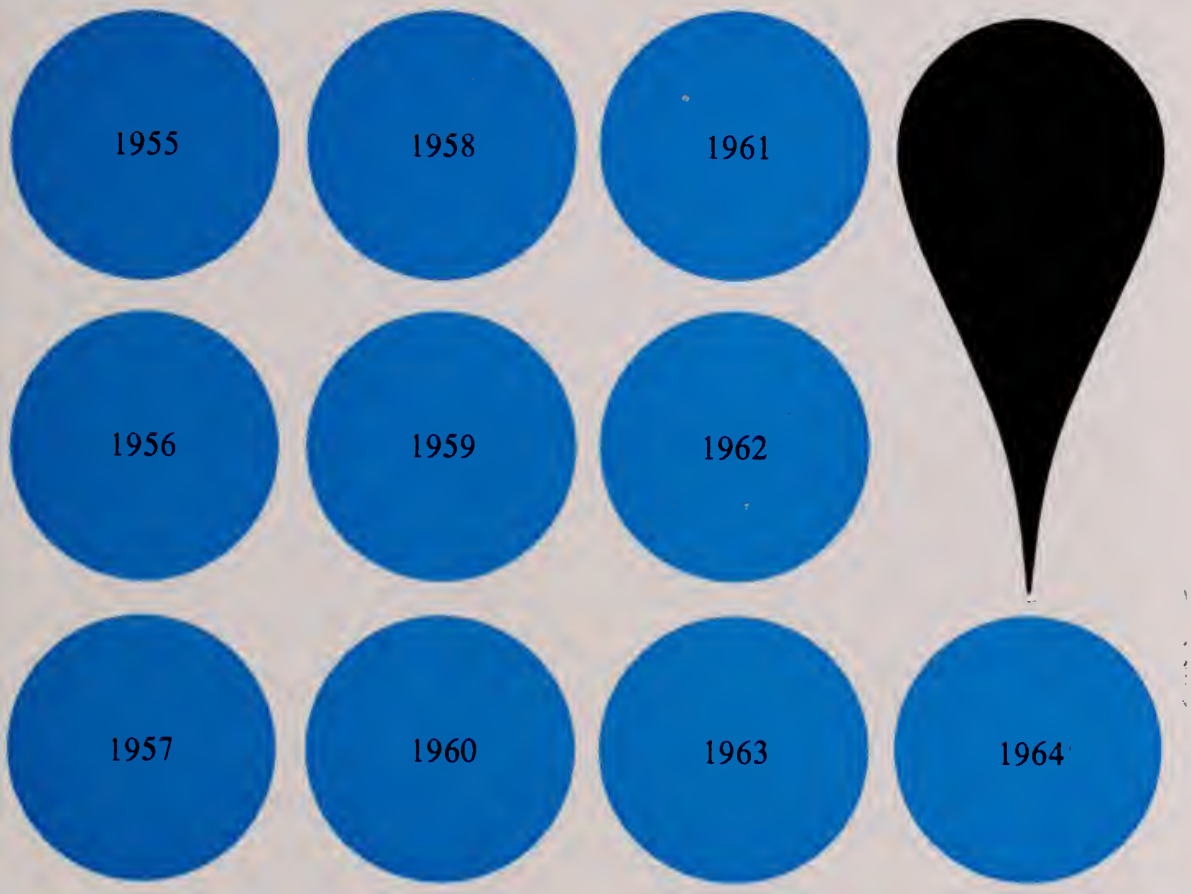
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[1] Simon, F. & Bernstein A.: "The Treatment of Obesity in Patients with Cardiovascular Disease," Angiology, *12*:32-37, Jan. 1961.
[2] Plotz, M.: Modern Management of Obesity, J.A.M.A. *170*:1513-1515 (July 25) 1959.
[3] Bernstein, A. & Simon, F.: "Treatment of Obese Diabetics and Arteriosclerotics," Clin. Med. 907-920, May 1961.

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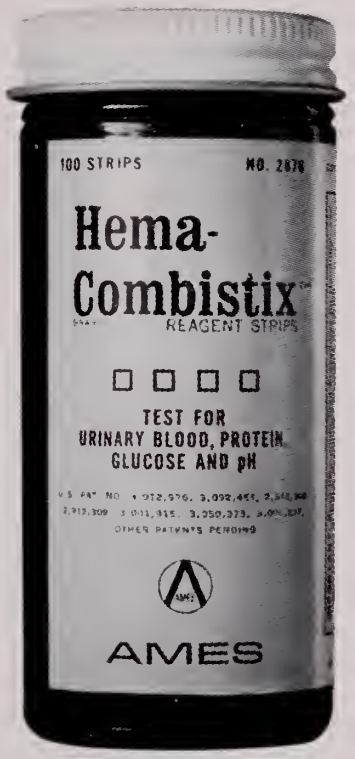
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Vol. 51, No. 7

The JOURNAL of the Florida Medical Association

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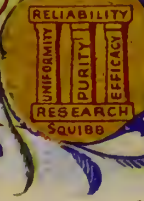
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References: 1. Szymanski, F. J.: *Indust. Med.* 30:498, Nov., 1961. **2.** Wexler, Louis: *Clin. Med.* 70:404, Feb., 1963. **3.** Hodges, F. T.: *GP* 14:86, Nov., 1956. **4.** McLean, I. E. D.; Graham, K. T., and East, M. O.: *Practitioner* 189:82, July, 1962.

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Volume 51, Number 7, July 1964

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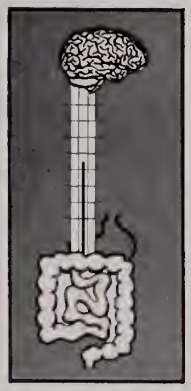
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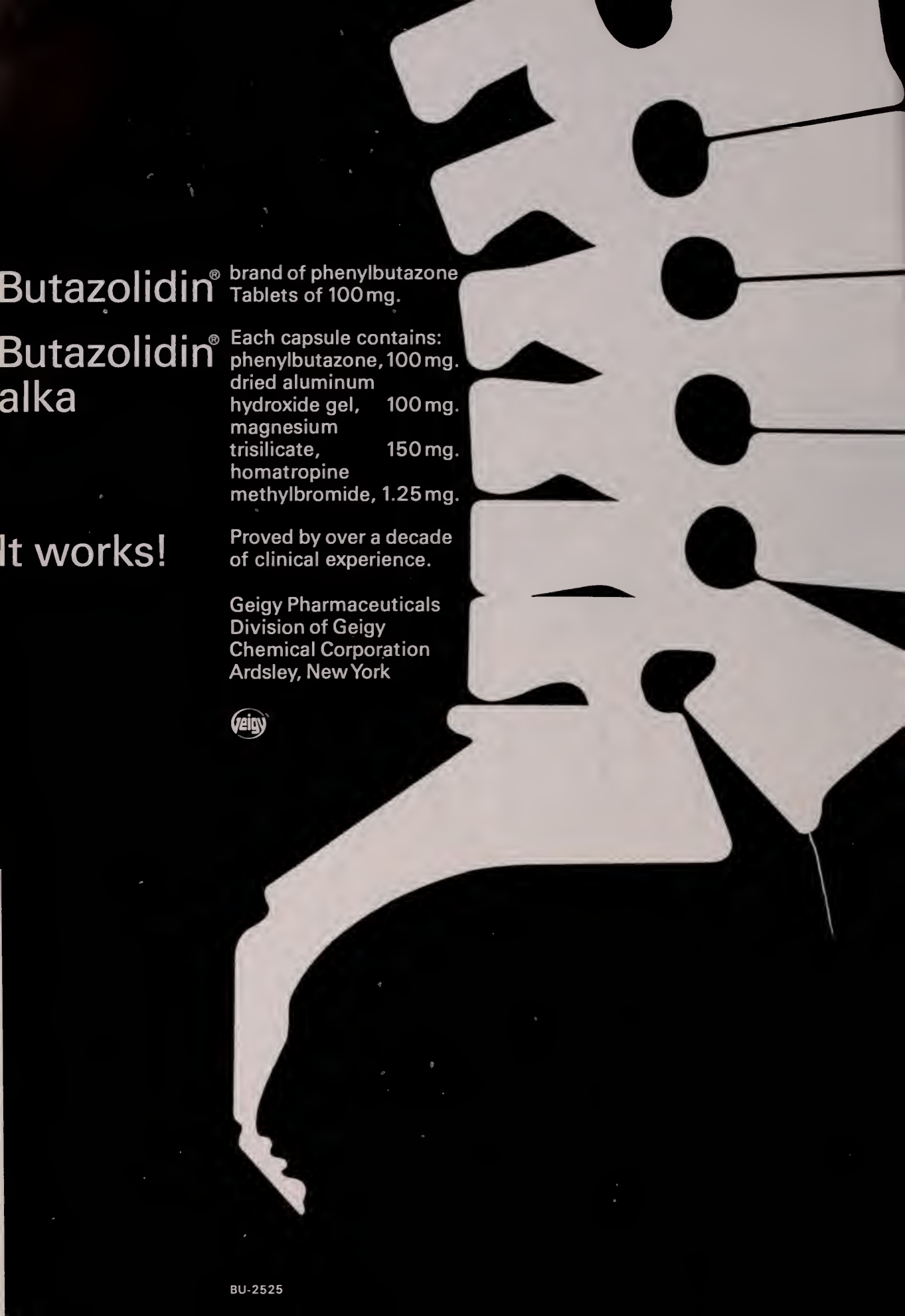
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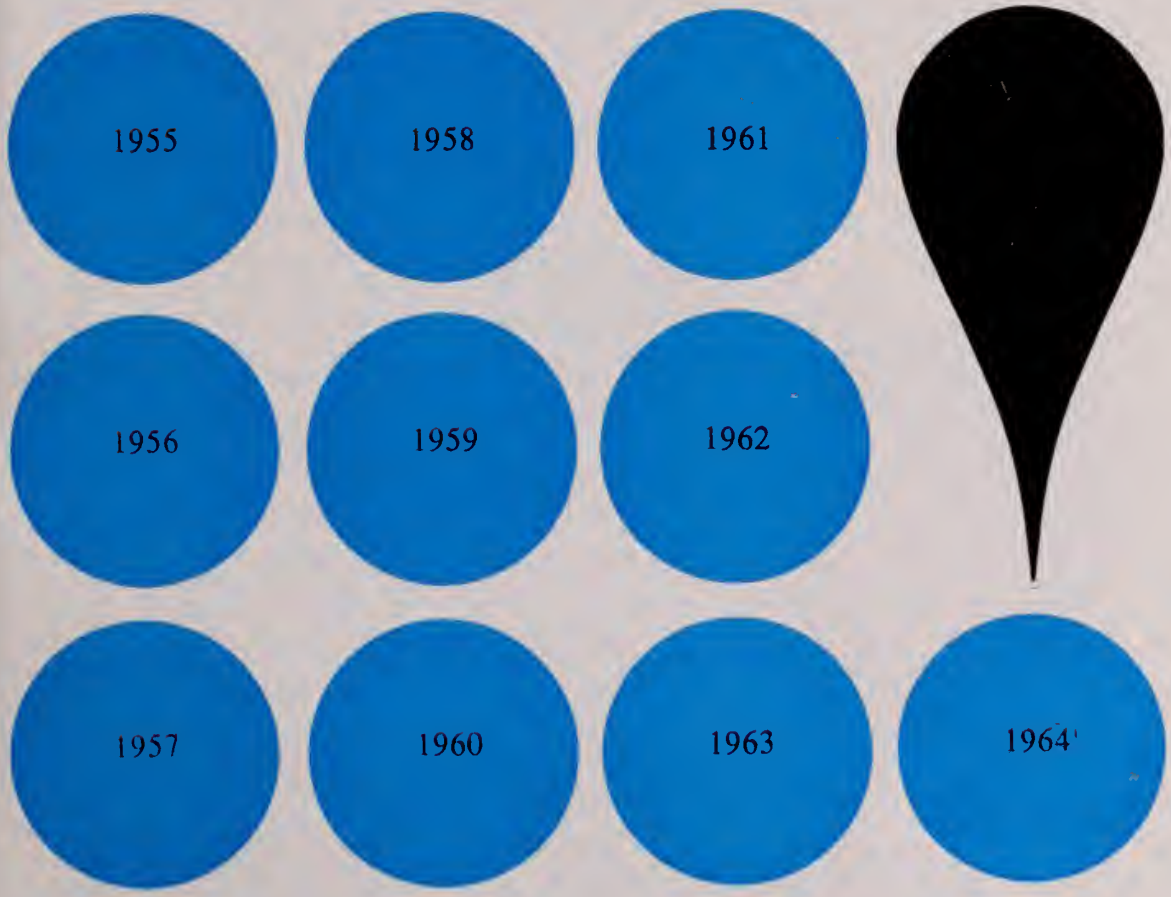
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AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).

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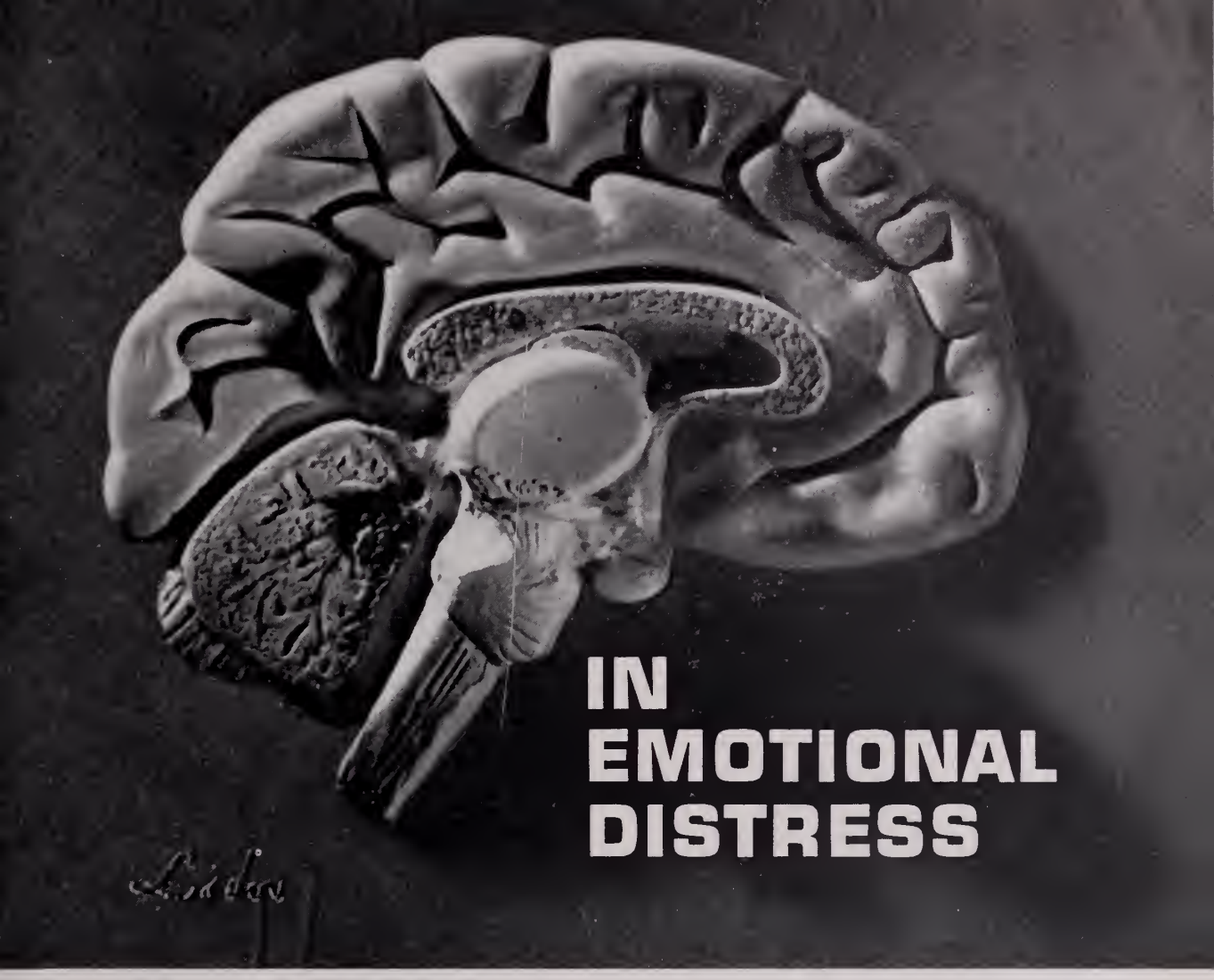
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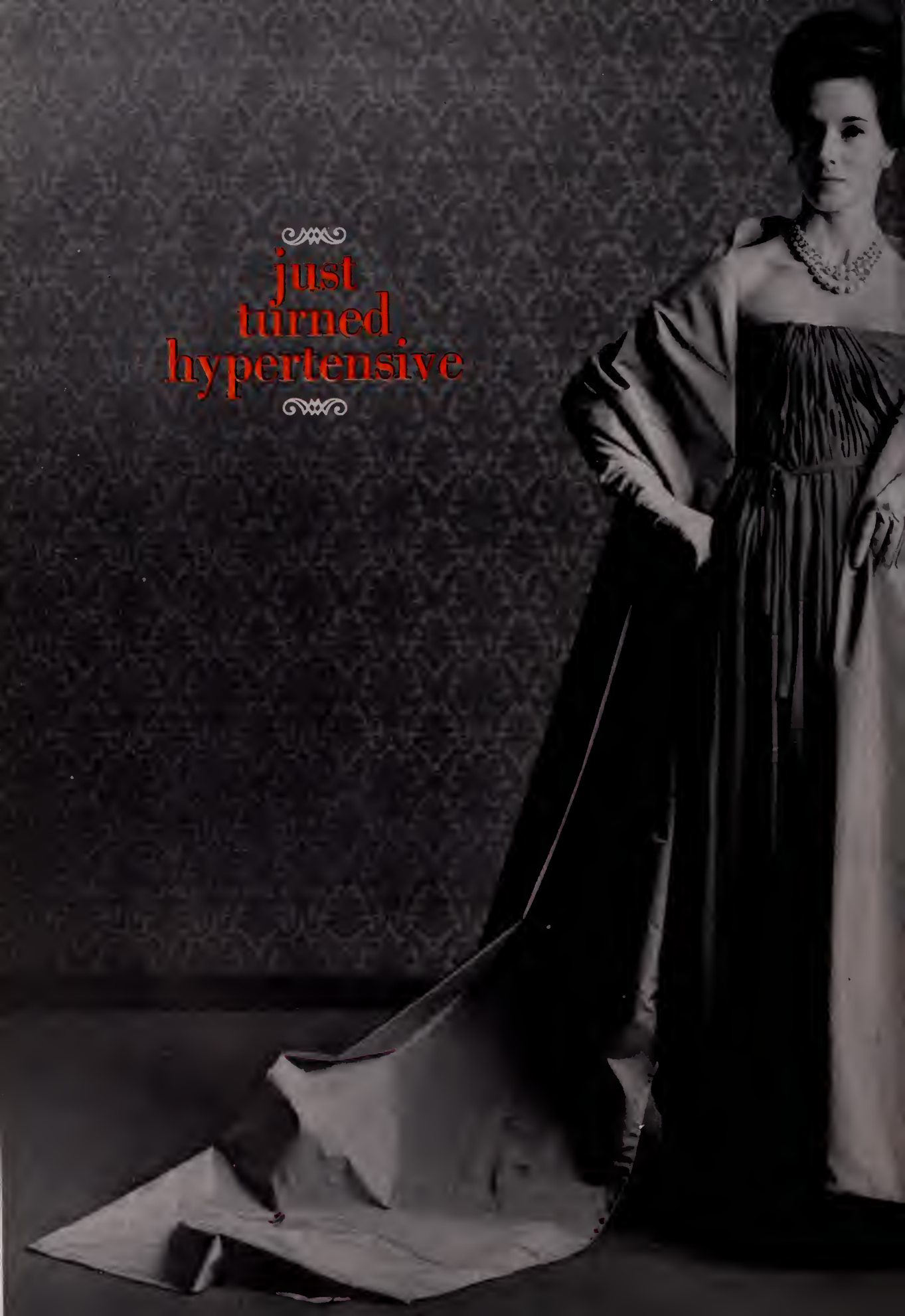
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CONTRAINDICATION: Anuria.



1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.
2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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The JOURNAL
of the Florida Medical Association



SHALER RICHARDSON, M.D.
1891 - 1964

One Man's Philosophy

WARREN W. QUILLIAN, M.D.
CORAL GABLES

No specific subject is assigned to the President when, in the By-Laws, there is included the duty of delivering an address at the annual meeting of the House of Delegates. It is his prerogative, therefore, to select a topic which will reflect, in general, a philosophy of medical practice as interpreted through personal experience over a considerable period. If the remarks seem to be, in part, subjective rather than objective in concept, please remember that the author has been actively engaged in clinical medicine during a time characterized by many changes, both in techniques and procedure.

From a precarious infancy, undernourished childhood and lively adolescence the Florida Medical Association achieved maturity without serious setbacks. Yet, amazingly, although she has reached the ripe old age of 90, her strength and vitality seem to be more vigorous than ever before. This remarkable physiological phenomenon has been made possible by the constant rejuvenation and replenishment of talent, enthusiasm and skills provided from new members through the years. A transfusion of varied interests and of capabilities annually enriches her strength to combat threats, and to meet the hazards of adjustment to changing needs in modern times.

Our Present Status

Let us consider some of these needs, and reflect upon possible methods of solving them. You are familiar with our aims, performance and growth as an Association. Recent accomplishments, in this respect, are recorded for your consideration in the reports of the Board of Governors, in the communications of Committees through the various Councils, and in the business agenda of this meeting, as indicated in your Handbook.

But, resting on our laurels is an uncomfortable position. Shakespeare in The Tempest (Act II) has the character, Antonio, to say: "What's past is prologue; what to come, in yours and my discharge." We have a rendezvous with the future, which should stir our minds and energies for the years ahead. The basic aims of Medicine have been fundamentally the same since the beginnings of recorded history: the proper recognition of human ills, and attempts to improve the skills of those responsible for their relief. Our present status is, in part, a wonderful heritage from the efforts of medical educators, who have borne much of the responsibility. Many problems have arisen because of diverse complexities of administration, advances in science, and the ever increasing demands for changed emphases in medical education and training. Inevitably, there have been certain modifications of educational methods for the practice of Medicine as a profession. Many of these changes, with increased emphasis upon research, have created difficulties, the answers to some of which we do not now know.

In our planning, great importance must be given to the ultimate objective sought by the majority of medical students—care of the sick. With the entry of government into medical research, tremendous sums of money have become available. Grants from various sources have required the services of more physicians for full time academic positions. This condition leaves fewer well trained practitioners to look after the patients who have traditionally depended upon their personally selected physician for help in sickness and in health. The Teaching Institutes of the Association of American Medical Colleges for the past decade have provided a great stimulus for the careful study of medical teaching, content of curricula, and the adaptation of both to the needs of physicians as they relate to a changing world. So, there is hope in the future!

Medical Schools and the Physicians' Responsibility

In recent years, several factors have combined to place Medicine in a poor competitive position

Read before the Florida Medical Association, Ninetieth Annual Meeting, Hollywood, May 7, 1964.

among the professions as a career choice. The relative number of applicants for the classes in Medicine has recently declined, while, during the same period, there has been an increased enrollment in sciences other than Medicine. This latter fact might, conceivably, make inroads upon the talent supply, thus reducing the quality, as well as the quantity, of students in Medicine. The greater popularity of other sciences may be partially due to the longer period of study and burden of rising costs, without subsidy, for the medical student. Many efforts are now being made to help the medical student with loan funds during his years of greatest need. It would seem that the same skills which have developed industry and technological advances, and have unveiled some of the mysteries of space travel, might be applied toward this problem, the solution of which will mean so much to the future well-being of the people.

If we are to have a future worthy of comparison to the past, there is much work to be done. What is the purpose of our existence as a profession? Is it not a need for the highest quality of medical care? We are not so concerned with volume. The important factor is quality. Standards must be kept high, and excellence must be maintained. At the 60th Annual Congress on Medical Education, sponsored by the Council of Medical Education of the American Medical Association in February 1964, plans for continuing education of the physician were revealed. These include approved postgraduate seminars, audiovisual methods, and techniques for dissemination of knowledge. All of this planning is done for the maintenance of high standards. And we should feel very proud of the leadership manifested by the Florida Medical Association in the provision of approved postgraduate studies throughout the state.

Renewed emphasis has, during the past year, been placed upon recruitment of new students in health careers, both at a high school and college level. Again, the fine work being done by our Woman's Auxiliary with its program in these activities has been outstanding. The physician has a responsibility to help in the search for qualified students in order that tomorrow we may continue to have a strong profession. Coordinated effort is needed. Medical clinician and basic scientist seem recently to have moved closer in communication and understanding, a process which will inevitably result in superior medical teaching and more practical research efforts. Modern medicine is more



Dr. Warren W. Quillian of Coral Gables delivers his Presidential Address to the House of Delegates.

interesting and more satisfying, but it brings additional responsibilities.

Physician-Patient Relationship

This has been called the golden age of Medicine. Yet, the very system which has given to the people the best medical care in the world is the target of constant criticism. Why has public opinion changed in relation to the esteem held for physicians by other citizens of the community? The image of Medicine is simply an extended likeness of the physician and his colleagues, reflected in the mirror of public opinion. It can be warm and sympathetic, or cold and impersonal. Actions are more important than words, and words are without value unless supported by deeds. Yet this image can become distorted by false interpretation, and by efforts to misconstrue some of our actions. While we have been perfecting ourselves as scientists, strong forces have entered to change our environment, and are ready to alter our way of life.

Importance of the personal relationship between the physician and his patient cannot be overestimated. The close bond existing between a sick person and his doctor requires something more than a scientific approach to the medical problems involved. Encouragement for the depressed and disheartened, understanding, compassion, and consideration for feelings or prejudices are all

necessary factors in practice, which help to constitute the art of Medicine. Scientific medicine, alone, may cure the body. But, used alone, it may leave the mind embittered. Each one of us must share a portion of this responsibility to practice the art as well as the science. Interposition of the government, as a third party, might very well affect, adversely, the opportunity of the patient to receive kindly, interested care, since the physician would not find it possible to treat individual patients according to specific requirements.

Medical Care for the Aging

The family formerly assumed responsibility for their own health and welfare; especially for that of their elderly members. But present trends are in the opposite direction. We have always thought that organized government exists to serve the people without destroying the individual. If the increasing dependence upon the federal government for protection and security is carried to the point of destroying personal initiative and pride in work well done, a new disease will be created which is much more difficult to treat than many now found in clinical practice. We must provide incentives to encourage useful latter years, not legislation to promote idleness. Our hope for tomorrow must be concentrated upon effective action, based upon sincere convictions, to counteract this trend.

The philosophy involved in our implementation of the Kerr-Mills Law (1960) is that our aging citizens who need medical care should get it, whether or not they can afford to pay for it. As of March 15, some 32 states have adopted this Plan, despite its imperfections, as a practical approach toward the provision of help for needy older people. Legislation is pending in 11 other states. As with any other program of similar magnitude, inequities will arise, which must be corrected. It is locally administered by people who know the background and the needs of the recipients. If given a chance and properly implemented, it should provide the solution to many problems of the needy sick, at a fraction of the cost involved in other proposed plans now under consideration. Many of our healthy, older citizens would be far happier if they might continue productive lives long past the time when some are literally forced to retire by government regulation or by rules of union and management. Yet, all, by such practices, are placed in the same category at a given chronological age. The American public, collectively, should be educated concerning the importance of this to them, individually. Prolongation of life, as a result of increased medical knowledge, has in itself created some of the sociological problems which we face today in this country. These older citizens are flocking to Florida, as a haven, when their work days are past. Abrupt changes, with variations in daily routine, create uncertainty and confusion, especially among the elderly. And this condition adds problems for the practicing physicians of Florida.

Varied Responsibilities of the Physician

We have an additional obligation and duty to accept our position as respected leaders of the community. Some of the needs demanding our help are not primarily medical, but may be educational, political or civic in origin. Individual patients consider their own personal physician as a fine, dedicated person to whom they may turn with confidence. Yet the profession, as a whole, has sometimes been described as callous, unfeeling, and interested largely in money grabbing. This distortion can best be disproved by our individual lives and by acceptance of responsibilities outside the field of Medicine.

Under very able leadership, our Woman's Auxiliary has met this challenge. In association with the wives of other physicians and highly respected by nonmedical club women, its members exert tremendous force in their activities. They are showing the public that our families constitute a vital part in every community. Daily they contribute to the educational and cultural life of the area through their programs, working with us toward the same goals for the preservation and enhancement of our heritage in American Medicine.

Our role as guide, counselor and friend, need not be lost just because the modern doctor has more to offer than his granddaddy in Medicine. The high ideals and responsibilities of our profession demand and deserve the best that is within us. Ours is a good life, filled with rewarding experiences. To know that some are alive and well, who, except for our skill and efforts, might have been dead; to know that there is less pain and suffering, less anxiety and fear—these are some of the rewards of the true physician.

Conclusions

Medicine progresses, even in a troubled world. Changes in government, in laws and controls, have not interfered with this progress. Civilizations of the past have been destroyed by decay and greed within their own structure. Let us renew our faith

in the simple basic principles which have characterized the growth and development of the Florida Medical Association through a period of almost a century. The price of success involves a determination to reach our objectives, regardless of adverse circumstances. It requires concentration on the immediate problems, and upon long range plans for fulfillment of our obligations to the people of Florida—our patients. Frustration and differences of opinion are inevitable. Changing conditions require flexibility in our adaptation to existing needs. Even though our eyes are upon the stars, we must still keep our feet upon the ground. Our responsibilities are very great. But we can keep faith with those who have gone before, attempting to retain the confidence and trust of the people, as did our fathers, by holding high the banner of service. Integrity and service are the watchwords of excellence.

A beautiful guide and standard for the physician may be found in the Oath and Prayer of Moses Maimonides, a twelfth century member of the medical profession, who is quoted by Dr. Robert B. Greenblatt, in his recent, fascinating volume, "Search the Scriptures."[1] It reads, in part:

"O, grant—
That neither greed for gain, nor thirst for fame, nor vain ambition,
May interfere with my activity.
For these I know are enemies of truth and love of men,
And might beguile one in my profession
From furthering the welfare of Thy creatures.
O strengthen me.
Grant energy unto both body and the soul
That I might e'er unhindered, ready be
To mitigate the woes,
Sustain and help
The rich and poor, the good and bad, enemy and friend.
O let me e'er behold in the afflicted and suffering
Only the human being.

1. Greenblatt, R. B.: Search the Scriptures, Philadelphia, J. B. Lippincott Company, 1963, p. 121.

140 Alhambra Circle.

Board of Governors — 1964 - 1965



Members of the Board of Governors for 1964-1965 include (seated left to right) Dr. Floyd K. Hurt of Jacksonville; Dr. Eugene G. Peek Jr. of Ocala; Dr. Franklin J. Evans of Coral Gables; Dr. Samuel M. Day of Jacksonville; Dr. H. Phillip Hampton of Tampa, and Dr. Warren W. Quillian of Coral Gables. Standing are (from left) Mr. W. Harold Parham of Jacksonville, Executive Director of the Association; Dr. Robert E. Zellner of Orlando; Dr. Jack Q. Cleveland of Coral Gables; Dr. Chas. J. Collins of Orlando; Dr. Edward L. Cole Jr. of St. Petersburg; Dr. Leo M. Wachtel of Jacksonville, and Dr. Gordon H. McSwain of Arcadia. (Members absent—Dr. Henry J. Babers Jr., Gainesville and Dr. Reuben B. Chrisman Jr., Coral Gables).

Proceedings
Ninetieth Annual Meeting

Florida Medical Association, Inc.

Hollywood-by-the-Sea, Florida, May 7-10, 1964

General Session

The General Session of the Ninetieth Annual Meeting of the Florida Medical Association was called to order at 11:00 a.m., Friday, May 8, 1964, in the Convention Hall of the Diplomat Hotel, Hollywood-by-the-Sea, by President Warren W. Quillian.

Dr. Quillian stated that this general session was devoted to the President's Guest Speaker and welcomed the members of the Association, its Auxiliary and guests.

Dr. Quillian advised that he wished to utilize this occasion for a special presentation and introduced George S. Squibb, Esquire, director of sales for E. R. Squibb & Sons and great-grandson of Dr. Edward R. Squibb, founder of the company.

Mr. Squibb presented a hand-rendered, aluminated, parchment reproduction of E. R. Squibb & Sons' now famous "Priceless Ingredient Story" to Edward R. Annis, M.D., President of the American Medical Association. In making the presentation, Mr. Squibb stated that "the special award was being made in recognition of Dr. Annis' deep respect for the Squibb credo and as a tribute to his own personal honor and integrity as exemplified in 'The Priceless Ingredient Story.'"

In response. Dr. Annis thanked Mr. Squibb both on behalf of himself and the physicians of the nation and read the text of "The Priceless Ingredient Story." (This appears on page 402A of The Journal.)

Dr. Quillian introduced his guest speaker with the following remarks: "The bigger the man, the less one needs to say about him. James W. Young, President of the American Association of Advertising Agencies, introducing Calvin Coolidge, said: 'Ladies and Gentlemen, the President of the United States.'

"Ridiculous encumbrances are unnecessary in the introduction of our speaker today. You all know his background, and the magnificent record he has made in his present position. He speaks with authority. He is the personal friend of many of us. Constantly, he has been the fearless exponent of the needs and requirements of modern medicine, and the necessity for its freedom and preservation. As a very articulate spokesman, he has become known as the 'voice of the A.M.A.'

"I take great pleasure in presenting to you, Dr. Edward R. Annis, President of the American Medical Association, and of the World Medical Association.

"Welcome home, Ed."

Dr. Annis presented an informative and graphic account of current medical practice and medical services in European nations which he had visited recently, relating them to the quality of medical services in this country.

He painted a bright picture of dedicated physicians and an abundance of modern hospitals in the United States compared to miserly conditions in many European countries. He commented that after discussions with practicing physicians, researchers and teachers in Europe, at no time did he run into any physician who complained in terms of income and that dollars were not the issue. Neither is there any lack of talent in these countries nor a lack of good teaching. Some people in some cities in most countries from some doctors can get what he would call first class medical care; however, there is a great waste of talent and knowledge on the continent and this includes England. Many men and women, whose heads are filled with knowledge and skills that they have acquired, have no place to use these very same skills.

The family doctor there has no status and is looked on as a civil servant—often without respect. These men have no place to use their skills and, after graduation, the young ones have no place to go until a vacancy opens for them. Fine



Dr. Edward R. Annis of Miami, President of the American Medical Association, is congratulated by Mr. George S. Squibb of New York City, Director of Sales for E. R. Squibb & Sons following presentation of the hand-rendered, aluminated, parchment reproduction of E. R. Squibb & Sons', now famous "Priceless Ingredient Story."

doctors are tied down to routines and have to wait for a promotion.

Under their system of government expansion of facilities and services is totally left to the responsibility of government. In those same governmental agencies there are relatively few, if any, who are attuned to the knowledge of the science of medicine and its progress, so that they can demand and see that medical services are given equal priority with the building of roads, schools, public buildings, et cetera.

The big difference between our country and most of those and the reason that we have medicine available to so many people is the system of voluntarism under which this country operates. We have a peculiar system where people have the distinguishing characteristic of being willing to give their time, talents and money working together to accomplish things for their own people—their own loved ones—at home, without total recourse to government.

Dr. Annis closed his remarks with a few statistics:

"Since the turn of the century, we have doubled our population, we have tripled the population of those over the age of 65, who now number 18 million. We have one million people in this country today over the age of 85; we have 12,000 in this country today over the age of 100 years.

"I have seen microscopes that can magnify a million times. I have seen chemical micro computers that they tell me—I am not sure—but they tell me they can tell the analytical component of the chemistry of the cell itself, and with the new knowledge on the horizon—with the knowledge coming out of the laboratories of pharmacy—where 80 per cent of the drugs we use today were not even in existence 13 years ago, we are really making progress.

"A number of our medical schools have expanded their facilities and if they used to enroll 80 new students a year, now they are taking 90 to 100. Since the war, we have opened nine new medical schools, five more are being built or are in the blueprint stage today, and six more are being planned. We are turning out more doctors per population than at any time in history.

"Put all of these things together, you begin to realize that—'we ain't seen nothing yet!' It's just the beginning."

First House of Delegates

The House of Delegates of the Florida Medical Association convened at 9:30 a.m. on Thursday, May 7, 1964 in the Convention Hall of the Hotel Diplomat, Hollywood, Florida, with Dr. Eugene G. Peek Jr., Speaker of the House, presiding.

Dr. Quillian: "Mr. Speaker, Members of the House of Delegates, other members of the Association, Honored Guests and Friends: The entire organization of the Florida Medical Association is delighted to have you here to help open the Ninetieth Annual Meeting. We appreciate so much your willingness to work during the past year in the affairs of the organization and we find more and more that we must combine and multiply our talents if we are going to accomplish the solution to the problems that are set before us.

"It is a special privilege to me to introduce to you Dr. John H. Hanger, Pastor of the First Methodist Church of Coral Gables. He ministers to the congregation of which I am a member, and he has many friends among you from all sections of the state, particularly from Duval County where he formerly served in Jacksonville.

"Please stand while Dr. Hanger gives the invocation."

Dr. Hanger: "Let us pray.

"We thank thee, God, our Father, that thou hast created us with a desire to be of service to our fellow man; that we find in our own lives the greatest self expression when we feel that we have been of service to a neighbor or to one in need; that we have been taught and have learned by our own innate senses to recognize greatness in the one who serves. The Son of Man said, 'He that is greatest among you, let him be the servant of all.' For these who have entered into a calling, a profession, an avenue of service to their fellow men, we give thee thanks. For the lives that they touch, the bodies that they help to heal, for their ministry, accept our gratitude. Now we ask thy blessing upon them as they come together to enrich their fellowship, to establish their work, to learn new skills and understanding of problems that they shall face. Continue to be before them the great example of service, we pray. Bless this assemblage from the morning session until its close, we earnestly pray in Jesus' name. Amen."

The Speaker announced the membership of the Credentials Committee: Irving H. Hall Jr., M.D., Chairman, William A. Shaver, M.D., and Frederick F. Crews, M.D.

The Chairman of the Credentials Committee announced that a quorum of delegates had been registered and moved that they be seated.

Motion was seconded and carried.

Delegates

ALACHUA—John W. Andrews, William F. Enneking, Taylor H. Kirby Jr., Walter E. Murphree, Edward R. Woodward.

BAY—*(Absent—William F. Humphreys Jr., Joseph H. Morris).*

BREVARD—Jack T. Bechtel, Theodore J. Kaminski, Arthur C. Tedford—*(Absent—Allen E. Kuester, Ben C. Storey).*

BROWARD—Curtis D. Benton Jr., Miles J. Bielek, Russell B. Carson, Gordon B. Carver, Leonard A. Erdman, Frederick J. Fisher, Anthony C. Galluccio, Walter J. Glenn Jr., Paul E. Gutman, David J. Lehman Jr., John R. Mahoney, John H. Mickley, W. Dotson Wells, Scottie J. Wilson.

CHARLOTTE—*(Absent—Carl N. Reilly)*

CLAY—William A. Mulford.

COLLIER—William J. Bailey.

COLUMBIA—Frank E. Adel.

DADE—James L. Anderson, Morris H. Blau, Richard C. Clay, Jack Q. Cleveland, Francis N. Cooke, Milton M. Coplan, Vincent P. Corso, Edward W. Cullipher, DeWitt C. Daughtry, Richard C. Dever, Robert F. Dickey, L. Washington Dowlen, Richard M. Fleming, M. Eugene Flipse, James J. Hutson, Paul S. Jarrett, Albert C. Jaslow, Marvin G. Flannery, David Kirsch, Banning G. Lary, Donald F. Marion, Elwin G. Neal, Edwin P. Preston, Walter W. Sackett Jr., T. Douglas Sandberg, Ralph S. Sappenfield, William A. Shaver, Clifford C. Snyder, William M. Straight, Chauncey M. Stone Jr., Robert L. Tindall, Nelson Zivitz—*(Absent—Julius Alexander, Edward R. Annis, Rufus K. Broadaway, Charles R. Burbacher, O. Whitmore Burtner, Victor D. Dembrow, Franklin J. Evans, Maurice M. Greenfield, Thomas W. Hutson Jr., Alfred G. Levin, Harold Rand, George W. Robertson III, Edward W. St. Mary, Charles F. Tate Jr., Paul N. Unger, Bernard Yesner, Joseph Zavertnik).*

DESOTO-HARDEE-GLADES—Gordon H. McSwain.

DUVAL—Samuel J. Alford Jr., Hugh A. Carithers, Clyde M. Collins, Thomas S. Edwards, John J. Fisher, W. Roy Hancock, Karl B. Hanson, Thomas M. Irwin, Edward Jelks, Joseph J. Lowenthal, Rothwell C. Polk, Harry W. Reinstine Jr., G. Dekle Taylor, John H. Terry, Leo M. Wachtel.

ESCAMBIA—A. T. Kennedy, John M. Packard, Walter C. Payne Sr., William M. C. Wilhoit, Earl G. Wolf.

FRANKLIN-GULF—*(Absent—J. Wayne Hendrix).*

GADSDEN-LIBERTY—Hilliard R. Reddick.

HIGHLANDS—Donald C. Hartwell.

HILLSBOROUGH — Ernest R. Bourkard, Chas. McC. Gray, Linus W. Hewit, Samuel G. Hibbs, Eugene B. Maxwell, William M. Myers, James N. Patterson, Madison R. Pope, Marshall E. Smith, William W. Trice Jr., James A. Winslow Jr.

INDIAN RIVER—Erasmus B. Hardee.

JACKSON-CALHOUN—James T. Cook.

LAKE—Frederick C. Andrews, Thomas D. Weaver.

LEE-HENDRY—James L. Bradley, James C. Carver, Edward W. Salko.

LEON-WAKULLA-JEFFERSON — Nelson H. Kraeft, George S. Palmer, Stuart C. Smith, Robert N. Webster.

MADISON—*(Absent—A. Franklin Harrison)*

MANATEE—Irving E. Hall Jr., Millard P. Quillian.

MARION—West Bitzer, Henry L. Harrell.
MONROE—Ralph Herz.
NASSAU—*(Absent—Benjamin F. Dickens)*
ORANGE—Louis P. Brady, Chas. J. Collins, Norman F. Coulter, Robert W. Curry, William R. Daniel, Truett H. Frazier, Harold Johnston, Louis C. Murray, Charles R. Sias, W. Dean Steward, Edward W. Stoner, Miles W. Thomley.
PALM BEACH—Willard F. Ande, James F. Cooney, Joseph C. Doane, Charles McD. Harris Jr., Russell D. D. Hoover, Richard F. Kidder, Philip O. Lichtblau, Myrl Spivey, John van Boven III, Malcolm S. Van De Water.
PASCO-HERNANDO-CITRUS—*(Absent—Gail M. Osterhout).*
PINELLAS — Clyde O. Anderson, William J. Dean, Charles K. Donegan, Ira C. Evans, Earl R. Fox, William H. Keeler III, Francis H. Langley, Jack A. MaCris, William G. Mason, Joseph E. Rawlings Jr., Howard L. Reese, Abbott Y. Wilcox Jr., Walter H. Winchester, Rowland E. Wood — *(Absent — John P. Ferrell).*
POLK—Paul E. Coury, John E. Daughtrey, Gordon R. Heath, Charles Larsen Jr., Willard E. Manry Jr., Arthur J. Moseley Jr., Frank Zeller.
PUTNAM—Fairfax E. Montague.
ST. JOHNS—Reddin Britt.
ST. LUCIE-OKEECHOBEE-MARTIN — John M. Gunsolus, Howard McDermid.
SARASOTA—John M. Butcher, Samuel E. Kaplan, Karl R. Rolls, Melvin M. Simmons, Millard B. White.
SEMINOLE—*(Absent—Thomas F. McDaniel).*
SUWANNEE-HAMILTON-LAFAYETTE — *(Absent—Owen R. Hunt Jr.).*
TAYLOR—T. Conrad Williams Jr.
VOLUSIA — C. Robert DeArmas, William H. Eyster, Richard C. Hartsfield, Charles L. Richerd, Russell L. Welsh.
WALTON-OKALOOSA-SANTA ROSA — Frederick F. Crews, William W. Thompson.
WASHINGTON-HOLMES—*(Absent—Walter E. Shehee).*
COUNCIL ON SPECIALTY MEDICINE — James D. Beeson, Jack H. Bowen, Fred A. Butler, Emmet F. Ferguson Jr., David W. Goddard, A. Mackenzie Manson, Sanford A. Mullen, Arthur J. Wallace, John H. Webb Jr.—*(Absent—Thomas E. Scott Jr., Edward W. Cullipher, J. K. David Jr., Bernard L. N. Morgan, Marlin C. Moore, Ivan Isaacs).*
OFFICERS AND EX-OFFICIO MEMBERS—Jere W. Annis, Reuben B. Chrisman Jr., Samuel M. Day, Burns A. Dobbins Jr., Franklin J. Evans, H. Phillip Hampton, Francis T. Holland, Floyd K. Hurt, Meredith Mallory, Eugene G. Peek Jr., Warren W. Quillian.

Motion was carried to approve the minutes of the 1963 Annual Meeting as published in the July 1963 issue of The Journal.

The Speaker introduced the officers of the Association: Dr. Franklin J. Evans, Vice Speaker; Dr. Warren W. Quillian, President; Dr. Samuel M. Day, President-Elect; Dr. H. Phillip Hampton, Vice President; Dr. Floyd K. Hurt, Secretary-Treasurer, and Mr. W. Harold Parham, Executive Director.

The Speaker then remarked:

Remarks of the Speaker

EUGENE G. PEEK JR.

The Speaker and Vice Speaker invites you to the Gay 90's—The 90th Annual Meeting of the Florida Medical Association and the 4th Annual Meeting of the House of Delegates of the Florida Medical Association held under the new Charter and By-Laws.

The Speaker would like to urge upon all Delegates and members of the Association that it is not only their privilege but their duty to appear before the Reference Committees to give their points of view concerning any resolution in which they are interested. With this in mind, the Speaker strongly recommends that you make a most careful study of the resolutions which appear in your handbook or packet prior to appearing before the Reference Committee. The Speaker and Vice Speaker wish to assure you that each will preside according to the principles of recognized parliamentary procedure. The Speaker urges each of you, if at any time you disagree with any rule or decision of the Speaker, please feel free to question the decision or to appeal the decision so that it can be immediately put to the vote of the House. In view of the extensive medical and legal background of your distinguished Vice Speaker, I have asked him to act as parliamentarian of this session. It is the duty of the presiding officer to expedite business of the House as much as possible; however, not to such a degree as to curtail the opportunity of any member to rise and be recognized at any time to discuss any matter before the House. The Speaker requests that the Delegates address all remarks to the Speaker so that there cannot possibly arise any conflict of personality between discussants. It is well again to remember the words of the first Speaker of the House of Delegates of the Florida Medical Association, Dr. Joseph S. Stewart, when he stated, "We are here to discuss resolutions and not to discuss personalities." Thank you.

Attention was called to the Travel Accident Insurance provided for all Delegates.

Several distinguished guests were introduced: Mrs. Abbott Y. Wilcox Jr., President, Woman's Auxiliary to the Florida Medical Association; Mrs. Willard L. Fitzgerald, President-Elect of the Woman's Auxiliary; Dr. Leo Smith, of Waycross, Fraternal Delegate from Georgia.

Dr. Quillian introduced The Honorable Chesterfield H. Smith, President-Elect, The Florida Bar.

Mr. Smith: "President Quillian, Distinguished Professional Colleagues:

"I bring greetings from the 8,600 lawyers who have allowed me to be at least one of their spokesmen. The Florida Bar attempts collectively to discharge our obligation to the public, to the Bench, to our profession itself, and I think that we do quite well. One of the reasons we have done quite well is because we watch very carefully the other learned professions and professional colleagues and we have seen that the most successful of all are the doctors. They have devoted a great deal of time to their obligations to the public and we are attempting to follow in their footsteps. I think we have made great steps forward.

"I came down simply to be friendly. We are meeting in convention assembled down the way at the Americana at this time also. We are having a good time. I like to talk to people of the learned professions. I like people in my own town of Bartow, and in Lakeland, and in Arcadia—where my friend I see sitting in front of me is from; I like doctors better than almost anybody else.

They are more fun to work with in civic activities, more fun to think and talk with, and more fun to fight and fuss with, and more fun to drink with than almost any other kind of people.

"I like them real well, and on behalf of lawyers everywhere, I find that to be true. I think that because we are a learned profession and because in truth and fact we do not have an inventory we do not have merchandise to sell, we have a kinship that makes lawyers and doctors compatible, very good golf opponents and friends everywhere.

"I do not have a message, but I will say this. I think there is a great area of closer cooperation that we can work at in the field of government regulation, and in the field of legislation. I think we ought to sit down and have our legislative committees — our goals — coordinated and see where we can help each other, because as professional people we must be vigilant to protect and preserve the individual relationship that professional people must have if they are to discharge the obligation that they assumed when they took on that status. We do not have too close a cooperation in this legislative field. During the administration this year I will try to do something about it and if President Quillian will join with me, maybe we can get our committees together and discuss some of the legitimate, joint, cooperative legislative goals that we can discharge together.

"On behalf of my colleagues who are not here, I bid you a happy, wonderful convention. Thank you."

Several other guests were introduced: Senator John McCarty, Board of Governors of The Florida Bar; Harry T. Gray, Esquire, FMA Legal Counsel, and Mr. H. A. Schroder, Executive Director of Blue Shield.

Dr. Quillian: "The Annual Award for Outstanding Community Service by a Physician has again been made available this year by the A. H. Robins Company. The recipient was chosen by the Board of Governors from nominees submitted by the various component county medical societies. Mr. Speaker, will you make the presentation? Only you can properly do it."

Dr. Peek: "It gives me great pleasure to present to you on behalf of the Board of Governors the recipient of the fourth annual A. H. Robins Company Awarded For Outstanding Community Service by a Physician. This award is presented to honor a Florida physician judged by his colleagues to have made a significant contribution to civic activities by manifesting widespread interest and participation in public affairs. Details of the recipient's many accomplishments and activities are in your packets, as they are too numerous to enumerate. He is a Past President of the Florida Medical Association and a person I have known very intimately for over 47 of his 82 years—my father—Dr. Eugene G. Peek Sr."

The recipient of the 1964 Community Service Award of the A. H. Robins Company is Dr. Eugene Goodbred Peek Sr., of Ocala. The award is presented annually to honor a member of the Florida Medical Association who is particularly interested in community affairs and renders distinguished public service. Dr. Peek was chosen for this honor by the Board of Governors of the Association from nominees submitted by the component county medical societies. A native son of Florida who decided as a mere boy to become a doctor, he achieved such overwhelming success in his chosen profession through hard work, keen intelligence, and an engaging personality that today he is regarded as one of Ocala's "Gentlemen of Distinction."

Dr. Peek was born on Feb. 27, 1882, in Lafayette County, the son of Thomas Glover Peek and Lucy Ann Goodbred Peek. He began his career at the age of 18 as a teacher in a one room school and received the tremendous salary of $20.00 a month. He had obtained his teacher's license without attending high school. In fact, when he took his examination, his only formal schooling had been obtained in a three room schoolhouse. When he obtained a scholarship to the Florida State Normal School at DeFuniak Springs, from which he was graduated in 1904, his only entrance qualifications were his teacher's certificate and the fact that he had obtained the scholarship through competitive examinations. On graduation, he taught for two years and worked his way through the Medical College of South Carolina, graduating in 1910, the same year he married the former Elizabeth A. Hobb of Moundsville, W. Va.

He opened his medical practice in Ocala in 1911 and has been perfectly content to remain there ever since. Dr. Peek built up an astonishing record in his profession, overshadowed only by his accomplishments in the civic life of Ocala, both reading like a Who's Who Directory.

On the medical side he has held many positions and honors. He is a past president and now a life member of the Marion County Medical Society. He was president of the Central Florida Medical Society, was a member of the Munroe Memorial Hospital Staff and is still on the honorary staff. He is a past president of the Florida Medical Association, having served in that capacity in 1943. He was a Fellow of the Southeastern Surgical Congress and a Fellow of the Academy International of Medicine. In 1963 he was honored by being awarded the Certificate of Appreciation by the Federation of State Medical Boards of the United States. He was for 20 years a member and is a past president of the Florida State Board of Medical Examiners. He is a life member of the Florida Medical Association, the American Medical Association, and the Southern Medical Association.

When it comes to discussing his civic accomplishments, one almost has to go right into his hobby for Dr. Peek heads his list of hobbies with the word "politics." He says that he has always loved it and still does, and he loves to be around Tallahassee doing a little work for the Medical Association. His first political office was chairman of the Ocala School Board of Trustees. He followed that by serving Ocala as a progressive mayor three different times, and he is proud that his first four year term saw the erection of the Munroe Memorial Hospital on which he served as a staff member for years. His terms also saw the remodeling of the city hall and the fire station. Dr. Peek served as president of the

Marion County Chamber of Commerce three different times and is now a director of the Florida State Chamber of Commerce and a member of its executive committee. He was a member of the State Democratic Committee for Marion County for 20 years, but resigned when in good faith "I couldn't go along and vote when those votes went along with such socialized medicine ideas." He calls himself a free thinker, although he readily admits that his wife calls him a "free talker." He believes deeply in the individual right of man to worship, vote, and think for himself, to form honest opinions and to stick to them unless he is proved wrong, then admit it.

Dr. Peek has a tall list of club memberships. He is a past president and a charter member of the Ocala Kiwanis Club, and holds a 50 year membership pin in the Masons. He is a member of the Morocco Shrine Temple, an Elk and a life member of Phi Chi medical fraternity. He has been a director of the Commercial Bank and Trust Company in Ocala since 1920.

Today at 82, Dr. Peek is an excellent example of how to retire and still enjoy life. He retains an active interest in the Cross State Canal Authority of which he was one of the original members, as he was of the State Improvement Commission. He is also a past member of the State Game and Fresh Water Fish Commission. A life member of the University of Florida Alumni Association, he is also an honorary member of the Florida Blue Key. He is a member of the Medical Advisory Board to the Medical Center at the University of Florida in Gainesville. He also serves as a member of the Advisory Board of Central Florida Junior College. He is a member of the State Crippled Childrens Commission, an elder in the Presbyterian Church, a member of the Advisory Board of the Salvation Army, and an honorary member of the Marion Hunting and Fishing Club. In addition to his hobby of politics, he is actively interested in gardening, hunting, and fishing. He also loves to watch and listen to football and baseball games.

Dr. Peek is the father of two children, a daughter, Mrs. Virginia Peek Smith, and a son, Eugene G. Peek Jr. He has six grandchildren, and one great-grandson. He is affectionately known in Marion County and in Ocala as "Mr. Ocala."

Dr. Peek was asked to come to the podium and was given a standing ovation by the assembly.

Dr. Peek Jr.: "On behalf of the Board of Governors, it gives me pleasure, as you all know, with much emotion, to present this to my father."

Dr. Peek Sr.: "I must say that he certainly has kept this a secret. In fact, I had planned not to come to this meeting—but he sent word over by his wife, by my daughter, and a few more —saying, 'Dad, you better go down.' I never suspected anything of this kind. I thought I was proud when I was elected President of the Florida Medical Association but this, I feel, is the greatest honor I have ever received in my 82 years of experience. Thank you very much."

The Speaker then introduced Dr. Warren W. Quillian, President, who gave his annual address.

(The complete text of President Quillian's address begins on page 420.)

Dr. Quillian: "For many years, those of us who have been privileged to work closely with him in the affairs of the Association have admired the manner in which our Executive Director has discharged his duties. He has brought to the office a dignity and respect which merits our approval and our commendation. I, therefore, take great pleasure in presenting on behalf of the Board of Governors and its Executive Committee, who unanimously approved this action, to W. Harold Parham a citation, and I shall read it:



Presentation of the A. H. Robins Company Award to Dr. Eugene G. Peek Sr. of Ocala. Shown with him are Mrs. Peek and their son, Dr. Eugene G. Peek Jr.

RESOLUTION

January 12, 1964

Whereas, W. Harold Parham has been selfless in his devotion to the interests of Medicine and the Florida Medical Association, to the officers of the Association and to the physicians of Florida whom he serves, and

Whereas, he has faithfully served the Association for the past fifteen years in a manner which has provided the business affairs of our Association an administration which we feel is second to none in organized medicine, be it therefore

RESOLVED, That this Board of Governors offer to W. Harold Parham this expression of its appreciation for the fine contribution to medicine and to the doctors of Florida which he has made in his capacity as Executive Director of the Florida Medical Association.

Warren W. Quillian, M.D.
Samuel M. Day, M.D.
F. K. Hurt, M.D.
Robert E. Zellner, M.D.
S. Carnes Harvard, M.D.
Eugene G. Peek Jr., M.D.
Jack Q. Cleveland, M.D.
Leo M. Wachtel, M.D.
H. Phillip Hampton, M.D.
R. B. Chrisman Jr., M.D.
E. L. Cole Jr., M.D.
Ralph S. Sappenfield, M.D.
Henry J. Babers Jr., M.D.
Chas. J. Collins, M.D.

Mr. Parham: "Thank you very much. Words cannot express my deep appreciation."

The Speaker announced the personnel of Reference Committees as follows:



A citation in "appreciation for the fine contribution to Medicine and to the doctors of Florida which he has made in his capacity as Executive Director of the Florida Medical Association" is presented to Mr. W. Harold Parham at the First Meeting of the House of Delegates by Dr. Warren W. Quillian of Coral Gables, President. Dr. Eugene G. Peek Jr. of Ocala, Speaker of the House, is shown at left, and Dr. Floyd K. Hurt of Jacksonville, Secretary-Treasurer of the Association, at far right.

I. HEALTH AND EDUCATION
Donald F. Marion, Chairman
G. Dekle Taylor
Walter E. Murphree
Clyde O. Anderson
Scottie J. Wilson

II. PUBLIC POLICY
William J. Dean, Chairman
William M. C. Wilhoit
Louis C. Murray
Francis N. Cooke
Banning G. Lary

III. FINANCE AND ADMINISTRATION
George S. Palmer, Chairman
Edward Jelks
Gordon H. McSwain
James L. Anderson
L. Washington Dowlen

IV. LEGISLATION AND MISCELLANEOUS
James F. Cooney, Chairman
Thomas M. Irwin
Madison R. Pope
Melvin M. Simmons
Milton M. Coplan

He also announced that all meeting rooms for Reference Committees were listed in the Handbook, and reports and resolutions were either in the Handbook or in the Delegates' packets. Only one report had a supplement, the report of the Committees on Archives.

He called attention to the beautiful bouquet of red roses on each end of the table, presented by the Committee on Archives in honor of the members who have passed on since last year. The additional list of members who have died could be found in each Delegates' packet and this list was complete with the exception of one name—Dr. S. Carnes Harvard—beloved Past President and member of the Board of Governors. In memory of these members, the assembly stood for one minute of silent prayer.

The Speaker asked for additional reports or resolutions.

Dr. Ralph Jack, of Dade, presented a resolution on Opposition to Nationalization of Medicine, which was given number 64-20 and assigned to Reference Committee No. IV.

Dr. A. Mackenzie Manson, of Duval, presented a resolution inviting the Association to

hold its 92nd Annual Meeting in Jacksonville. This was given number 64-21 and assigned to Reference Committee No. III.

Dr. Walter W. Sackett Jr., of Dade, presented an amendment to Resolution 64-18, which was assigned to Reference Committee No. I.

A Delegate from Polk County called attention to an error in resolution 64-14. In the second "whereas," the word "adequately" should be changed to "inadequately."

Dr. Melvin M. Simmons, of Sarasota, announced that Resolution 64-19 was presented as an individual resolution in order to get it printed in time. The previous evening, the Florida Medical Scholarship Advisory Committee to the State Board of Health approved the resolution. Assignment of this resolution was changed from Reference Committee No. I to Reference Committee No. IV.

The Speaker announced that Blue Shield's Annual Meeting would be held at 11:00 a.m. following adjournment of the House of Delegates; that the President of the American Medical Association, Dr. Edward R. Annis, would speak on Friday at 11:00 a.m., and that the Woman's Auxiliary luncheon would be on Friday at 12:30 p.m.

The Chairman of the Credentials Committee gave a final report of 187 Delegates seated.

The House of Delegates recessed at 10:30 a.m. to reconvene on Sunday, May 10, at 9:30 a.m.

Second House of Delegates

The House of Delegates reconvened at 9:40 a.m. on Sunday, May 10, 1964 in the Convention Hall of the Hotel Diplomat, Hollywood, Florida, with Dr. Eugene G. Peek Jr., Speaker of the House, presiding.

Dr. Irving H. Hall Jr., Chairman of the Credentials Committee, reported that 191 Delegates were present and officially seated, constituting a quorum.

Delegates

ALACHUA—John W. Andrews, William F. Enneking, Taylor H. Kirby Jr., Walter E. Murphree—*(Absent—Edward R. Woodward).*

BAY—*(Absent—William F. Humphreys Jr., Joseph H. Morris).*

BREVARD—Jack T. Bechtel, Theodore J. Kaminski, Allen E. Kuester, Ben C. Storey, Arthur C. Tedford.

BROWARD—Curtis D. Benton Jr., Miles J. Bielek, Russell B. Carson, Gordon B. Carver, Leonard A. Erdman, Frederick J. Fisher, Anthony C. Galluccio, Walter J. Glenn Jr., Paul E. Gutman, David J. Lehman Jr., John R. Mahoney, John H. Mickley, W. Dotson Wells, Scottie J. Wilson.

CHARLOTTE—Carl N. Reilly.

CLAY—*(Absent—William A. Mulford)*

COLLIER—William J. Bailey.

COLUMBIA—Frank E. Adel.

DADE—James L. Anderson, Edward R. Annis, William G. Aten, Henry H. Bryant III, Richard C. Clay, Jack Q. Cleveland, Francis N. Cooke, Milton M. Coplan, Vincent P. Corso, Edward W. Cullipher, DeWitt C. Daughtry, Richard C. Dever, Robert F. Dickey, L. Washington Dowlen, Marvin G. Flannery, Richard M. Fleming, M. Eugene Flipse, Kermit H. Gates, Manuel A. Gonzalez, James J. Hutson, Ralph W. Jack, Paul S. Jarrett, Albert C. Jaslow, Walter C. Jones, Banning G. Lary, Donald F. Marion, John D. Milton, Charles A. Monnin Jr., Elwin G. Neal, Irwin Perlmutter, Edwin P. Preston, Walter W. Sackett Jr., Ralph S. Sappenfield, T. Douglas Sandberg, William A. Shaver, William M. Straight, Chauncey M. Stone Jr., Charles F. Tate Jr., Robert L. Tindall, Arthur W. Wood Jr., Nelson Zivitz—*(Absent—Morris H. Blau, Victor D. Dembrow, Franklin J. Evans, David Kirsch, Edward W. St. Mary, Clifford C. Snyder, Bernard Yesner, Joseph Zavertnik).*

DESOTO-HARDEE-GLADES—Gordon H. McSwain.

DUVAL—Samuel J. Alford Jr., Hugh A. Carithers, Clyde M. Collins, Thomas S. Edwards, John J. Fisher, W. Roy Hancock, Karl B. Hanson, Thomas M. Irwin, Edward Jelks, Joseph J. Lowenthal, Rothwell C. Polk, Harry W. Reinstine Jr., G. Dekle Taylor, John H. Terry, Leo M. Wachtel.

ESCAMBIA—A. T. Kennedy, John M. Packard, Walter C. Payne Sr., William M. C. Wilhoit, Earl G. Wolf.

FRANKLIN-GULF—*(Absent—J. Wayne Hendrix).*

GADSDEN-LIBERTY—*(Absent—Hilliard R. Reddick).*

HIGHLANDS—Donald C. Hartwell.

HILLSBOROUGH—Ernest R. Bourkard, Chas. McC. Gray, Linus W. Hewit, Samuel G. Hibbs, Richard S. Hodes, Eugene B. Maxwell, William M. Myers, James N. Patterson, Madison R. Pope, Marshall E. Smith, William W. Trice Jr., James A. Winslow Jr.

INDIAN RIVER—Erasmus B. Hardee.

JACKSON-CALHOUN—James T. Cook.

LAKE—Frederick C. Andrews, Thomas D. Weaver.

LEE-HENDRY—James L. Bradley, James C. Carver, Edward W. Salko.

LEON-WAKULLA-JEFFERSON—Nelson H. Kraeft, George S. Palmer, Stuart C. Smith, Robert N. Webster.

MADISON—*(Absent—A. Franklin Harrison).*

MANATEE—Irving E. Hall Jr., Millard P. Quillian.

MARION—West Bitzer, Henry L. Harrell.

MONROE—Ralph Herz.

NASSAU—*(Absent—Benjamin F. Dickens).*

ORANGE—Louis P. Brady, Chas. J. Collins, Norman F. Coulter, Robert W. Curry, William R. Daniel, Truett H. Frazier, Harold Johnston, Louis C. Murray, Charles R. Sias, W. Dean Steward, Edward W. Stoner, Miles W. Thomley.

PALM BEACH—Willard F. Ande, James F. Cooney, Charles McD. Harris Jr., Russell D. D. Hoover, Philip O. Lichtblau, Myrl Spivey, John van Boven III, Malcolm S. Van DeWater—*(Absent—Joseph C. Doane, Richard F. Kidder).*

PASCO-HERNANDO-CITRUS—*(Absent—Gail M. Osterhout).*

PINELLAS—Clyde O. Anderson, Robert A. Biles, William J. Dean, Charles K. Donegan, Earl R. Fox, William H. Keeler III, Francis H. Langley, Jack A. MaCris,

William G. Mason, Joseph E. Rawlings Jr., Howard L. Reese, Abbott Y. Wilcox Jr., Walter H. Winchester, Rowland E. Wood—*(Absent—Ira C. Evans).*

POLK—Paul E. Coury, John E. Daughtrey, Gordon R. Heath, Charles Larsen Jr., Willard E. Manry Jr., Arthur J. Moseley Jr., Frank Zeller.

PUTNAM—Fairfax E. Montague.

ST. JOHNS—Reddin Britt.

ST. LUCIE-OKEECHOBEE-MARTIN—John M. Gunsolus, Howard McDermid.

SARASOTA—John M. Butcher, Samuel E. Kaplan, Karl R. Rolls, Melvin M. Simmons—*(Absent—Millard B. White).*

SEMINOLE—*(Absent—Thomas F. McDaniel).*

SUWANNEE-HAMILTON-LAFAYETTE — *(Absent—Owen R. Hunt Jr.).*

TAYLOR—*(Absent—T. Conrad Williams Jr.).*

VOLUSIA—C. Robert DeArmas, William H. Eyster, Richard C. Hartsfield, Charles L. Rickerd, Russell L. Welsh.

WALTON-OKALOOSA-SANTA ROSA — Frederick F. Crews, William W. Thompson.

WASHINGTON-HOLMES—*(Absent—Walter E. Shehee).*

COUNCIL ON SPECIALTY MEDICINE — Jack H. Bowen, Fred A. Butler, Emmet F. Ferguson Jr., A. Mackenzie Manson, Sanford A. Mullen, Arthur J. Wallace *(Absent—James D. Beeson, Edward W. Cullipher, J. K. David Jr., David W. Goddard, Ivan Isaacs, Marlin C. Moore, Bernard L. N. Morgan, Thomas E. Scott Jr., John H. Webb Jr.).*

OFFICERS AND EX-OFFICIO MEMBERS—Jere W. Annis, Samuel M. Day, Burns A. Dobbins Jr., Franklin J. Evans, H. Phillip Hampton, Francis T. Holland, Floyd K. Hurt, Eugene G. Peek Jr., Warren W. Quillian, Robert E. Zellner.

BOARD OF PAST PRESIDENTS—Frederick K. Herpel, Eugene G. Peek Sr., Shaler Richardson, William C. Roberts.

Dr. Peek thanked Dr. Hall, Chairman of the Credentials Committee, Drs. William A. Shaver and Frederick F. Crews, members, for their work in certifying the Delegates.

The Speaker recognized guests from allied professions: Florida Medical Assistants Association, Mrs. Amy W. Stuller, President, Lakeland; Florida Society of Medical Technologists, Mr. Richard A. Carr, President, Orlando; Florida Division, American Society of Medical Technologists, Mr. William C. Ballard, President-Elect, West Palm Beach; Florida Chapter, American Physical Therapy Association, Martha Wroe, R.P.T., President, Gainesville; Florida Podiatry Association, Irvin H. Block, Pod.D., President, Miami Beach; Licensed Practical Nurses Association of Florida, Mrs. Lucille Walker, President, Ocala; Florida State Veterinary Medical Association, Hoyt C. Hall, D.V.M., President, Tampa, and Florida Nurses Association, Marion E. McKenna, R.N., President, Daytona Beach.

Expressing great pleasure at having him home again and seated as a Delegate from Dade County, the Speaker recognized Dr. Edward R. Annis, President of the American Medical Association.

Dr. Shaler Richardson was asked to stand and be recognized for attendance at his 43rd consecutive Annual Meeting of the Florida Medical Association.

Dr. Quillian presented to Dr. William B. Weil Jr., of the University of Florida College of Medicine, representing Dean George T. Harrell, a check in the amount of $4,805.41 from the American Medical Association Education and Research Foundation, which is a contribution free of all restrictions as to use, and because the American Medical Association pays the expense of solicitation and transmittal, every contributed dollar goes to the school. A similar check, in the amount of $4,807.91, was presented to Dean Hayden C. Nicholson, of the University of Miami School of Medicine.

The awards for Scientific Exhibits were announced: First prize—Florida Medical Association Committee on Veterinary Medicine, Clifford C. Snyder, M.D., Chairman, Joseph L. G. Lester Jr., M.D., George W. Karelas, M.D., Sidney Smith, M.D., Henry W. Shupe, M.D. Second prize—"Common Problems in Otolaryngology," John W. Stone, M.D. Third prize—"A Pilot Study in Mammography," Raymond E. Parks, M.D. Fourth prize—"Diagnostic Arteriography," Richard C. Connar, M.D., Ralph C. Aye, M.D.

The awards for Exhibit Visitation were presented: Paul S. Jarrett, M.D., a check for $301.00; John B. Henry, M.D., a check for $150.50. The third prize in the amount of $75.00 was previously presented to Chester M. Askue, M.D.

The special award of one week's stay at the Hotel Diplomat for two, with cabana and U-Drive-It, was won by Donald H. Altman, M.D., of Miami.

Dr. Quillian then announced the winners of the Golf Tournament: The Orlando Loving Cup for low gross—Richard L. Smith, M.D., of Coral Gables and the Duval Trophy to James F. Gallagher Jr., M.D. of Miami Shores for low net.

The Speaker sorrowfully informed the assembly that three of the Association's Past Presidents, Dr. Robert B. McIver, Dr. Frederick H. Waas, and Dr. Herbert E. White, were confined to the hospital in Jacksonville, and that Dr. White was not expected to live through the day; also, that Dr. David R. Murphey Jr., Past President, was in critical condition in a New York hospital.

Because of illness, Mrs. Meredith Mallory was asked to accept for Dr. Mallory the Association's fourth Certificate of Merit, which was awarded for exceptional and outstanding service to the Association, to the medical profession and to the public. Dr. Robert E. Zellner, of Orlando, made the presentation.

Whereas, Meredith Mallory, M.D., of Orlando, a life member of the Florida Medical Association, has rendered distinguished service to the medical profession, to the public, and for more than four decades to the Association, and is worthy of the Association's highest award, and

Whereas, This accomplished physician, born in Wichita, Kansas, on April 21, 1889, attended West Batavia High School, Batavia, Illinois, received the Bachelor of Arts degree from the University of Illinois in 1911 and the degree of Doctor of Medicine from the Harvard Medical School in 1915, completed an internship at Iowa Methodist Hospital, Des Moines, in 1916, and later engaged in postgraduate study at Harvard Medical School and Cook County Hospital, Chicago, and

Whereas, This young physician in 1916 entered the private practice of medicine in Des Moines in association wth Dr. Walter L. Bierring, was commissioned a first lieutenant in the Army Medical Reserve Corps in October 1917, became an instructor at the Officers Medical Training School at Ft. Oglethorpe, Georgia, was sent to Camp Meade, Maryland, in April 1918 where he served on the Heart Board and later on the Medical Service of the Base Hospital, receiving during this period a commission in the Medical Corps of the regular Army, resigned from the service in February 1919, returned to Des Moines and resumed practice in association with Dr. Bierring, soon afterward becoming a delegate from Polk County to the Iowa State Medical Society, and

Whereas, In November 1922 this able physician came to Florida to reside permanently in Orlando, was associated in practice there with Dr. John S. McEwan and Dr. Gaston H. Edwards until 1930, was chief of medical services at Orange General Hospital for many years, was president of the Orange County Medical Society in 1931, has been active in the Florida Medical Association for more than forty years, representing the Association in the House of Delegates of the American Medical Association from 1934 to 1944 and from 1959 to the present time, served on the Association's Board of Governors from 1953 to 1961, was Vice President of the Association at one time and has served at various times on several important committees, was for several years physician to Rollins College where he was awarded the honorary degree of Doctor of Science in 1947, became a fellow of the American College of Physicians in 1931 and a diplomate of the American Board of Internal Medicine in 1937, has served as a director of Blue Shield, has served as State Medical Consultant for the Florida Rehabilitation Agency since 1947, has been active in the American Medical Association and the Southern Medical Association through the years, and was a founder and in 1952 state chairman of the Florida Medical Committee for Better Government, and

Whereas, This renowned doctor has been active across the years in the civic and social affairs of his community, serving as a director of the local Red Cross, the Orlando Chamber of Commerce, the High School Athletic Association and the Orlando Athletic Association, and as president of the Orlando Civic Music Association, and holds membership in the American Legion 40 & 8, the Orlando Rotary Club, the University Clubs of Orlando and Chicago and the Chi Psi fraternity; therefore be it

RESOLVED, That the Certificate of Merit, the Association's highest honor, be presented to this eminent member of the Association, and outstanding citizen of Florida in recognition of his unselfish service and generous expenditure of time and effort in the interest of the public welfare and on behalf of the medical profession and, in particular, the Florida Medical Association.

REPORT OF REFERENCE COMMITTEE NO. I

Health and Education

Dr. Donald F. Marion: "Mr. Speaker, Mr. President, and members of the House of Delegates: Your Reference Committee on Health and Education gave careful consideration to items referred to it and makes the following report:

"The Reference Committee moves the adoption of the Report of the Council on Medical Education and Hospitals with the exception of recommendation 1 which should be amended to read, 'That the Florida Medical Association should immediately begin action to limit the construction of unnecessary hospital beds by means of regional planning boards; membership of which shall include adequate representation from the county medical societies.'" Recommendation 2 is referred to the Board of Governors for its consideration.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections; motion carried.

Council on Medical Education and Hospitals

HUGH A. CARITHERS, *Chairman*

Council:

The Council has been concerned with the following areas of activity during the year:

Visits with administrative and teaching personnel from the two medical schools have been accomplished by the Council, and it is believed closer liaison between official representatives of the Florida Medical Association and the medical schools would be of advantage to each.

Committees:

Medical Schools. — 1. University of Miami — The members of the Committee on Medical Schools have had several informal conferences and on March 12, 1964, the local members, Dr. Milton Coplan, Dr. Hayden Nicholson and Dr. E. W. Cullipher, met to discuss the problems in Miami. It is our consensus that: (1) The inadequacy of nursing care, the unavailability of operating time, and assigned anesthesia at Jackson Memorial Hospital, have forced the visiting staff to seek other hospital arrangements for care of private patients. (2) Divided responsibility between the Medical School and the Administration of Jackson Memorial Hospital is creating an increasing problem in the Medical School Teaching Program.

(3) A state pound law would be a great convenience and help to the Medical School. (4) A larger state subsidy to each medical student may soon need to be considered.

2. University of Florida — Members visiting the College of Medicine at the University of Florida on April 1 as representatives of the Council were: Drs. Emmet F. Ferguson Jr., James T. Cook, J. Maxey Dell Jr., David R. Moomaw, Donald R. Hagel and Hugh A. Carithers. It is recommended that (1) unused beds, already constructed and equipped, be utilized as soon as funds are made available; (2)plans for construction of an inpatient psychiatric center, combined with a training institute and a growth and development research facility, be facilitated; (3) expansion of the medical school be considered, especially if construction of a dental school is accomplished; (4) Florida physicians be kept informed concerning practice locations and accomplishments of graduates; (5) a pound law be passed; (6) the present policy regarding osteopathic physicians be continued, and (7) the improved relationship between members of the Alachua County Medical Society and full time staff members of the school be continued and that a liaison committee operate as vigorously as possible.

Hospitals. — **Recommendations: (1) That the Florida Medical Association should immediately begin action to limit the construction of unnecessary hospital beds by means of regional planning boards; membership of which shall include adequate representation of the county medical societies. (2) That the Florida Medical Association should immediately set new policies to prevent the conversion of small nursing homes into small hospitals with their subsequent coverage by Blue Cross of Florida, Inc. (3) That the Florida Medical Association should explore other possibilities than the Hospital Staff Utilization Committees to curb the overutilization of hospital beds.**

Internships and Residencies. — A questionnaire mailed to all Florida hospitals having approved internships or residencies, except Jackson Memorial Hospital and the J. Hillis Miller Health Center, indicated that there is still a pressing need for recruitment of house personnel. Included in the questionnaire was the following question concerning a brochure mailed to some 7,000 senior medical students at a cost of approximately $1,000, shared by the Association and the hospitals involved: "Do you have an impression as to the value of the distribution of a brochure such as the enclosed "Florida's Medical Climate" to medical students and first year interns as was done 2 years ago?" Most of the hospitals were favorable; three stated they had no evidence of value, and seven made no comment. One large hospital recommended expansion of the brochure allowing each hospital to have a statement concerning its program. Another hospital is still using the brochure in recruiting endeavors. Whether another edition should be attempted should be considered by the next committee, as well as by the Board of Governors.

Physician Placement. — As in past years, the Committee continued its dual function of (1) establishing policy for and supervising operation of the Association's physician placement service, which is administered by the Executive Office, and (2) serving, along with faculty representatives of the state's two medical schools, as advisory committee to the State Medical Student Scholarship Program, which is administered by the State Board of Health.

During the year, one official meeting was held on May 15, 1963. The remainder of the Committee's business was carried out by correspondence and telephone.

In the calendar year 1963, 772 openings were listed with the physician placement service, while the service assisted a total of some 650 physicians interested in finding practice locations in Florida. The average number of opportunities listed with the service at any given time during the year was 129; of physicians, 108. The following data pertain to (1) the opportunities listed, (2) the physicians assisted in each field of practice, and (3) the average number listed at any given time:

	Opportunities	Physicians	Average Number Physicians
General Practice	257*	154	25.7
Internal Medicine	75	134	22.3
General Surgery	6	82	13.7
Obstetrics and Gynecology	8	70	11.7
Radiology	13	48	8.0
Ophthalmology	19**	36	6.0
Urology	5	20	3.3
Pediatrics	26	17	2.8
Orthopedic Surgery	14	16	2.7
Psychiatry	13	13	2.2
Dermatology-Allergy	6	11	1.8
Anesthesiology	3	10	1.7
Industrial Medicine	25	9	1.5
Adm. & Institutional Med.	3	8	1.3
Otolaryngology	22	8	1.3
Pathology	0	8	1.3
Neurosurgery	4	4	0.7
Plastic Surgery	0	2	0.3
Misc. & Undifferentiated	273	—	—
TOTALS	772	650	

*Community Requests, 94

**Includes 7 E. E. N. T. openings

It is impossible to know how many of these physicians actually have located in the state and to what extent the placement service assisted each. Some, of course, are still seeking locations.

Because some openings remain unfilled over a period of time, it should not be assumed that the 772 opportunities shown are entirely separate and distinct. Many openings, especially rural community general practice opportunities, appear in a number of editions of the Florida Physician Locations listing, which is published approximately bi-monthly.

Recommendation: It is recommended that increased information and publicity concerning the Association's physician placement service be made available to the profession and to the public through all possible appropriate channels.

"The Reference Committee moves the adoption of the Report of the Scientific Council and wishes to emphasize the importance of this subject.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections; motion carried.

Scientific Council

THAD MOSELEY, *Chairman*

Council:

Your Council is pleased to report complete cooperation from committee chairmen through the 1963-64 period. The work of the Council has been carried on smoothly, and the work of the Committee on Scientific Work has been thorough, resulting in what is hoped will be an excellent state program.

Committees:

The Journal and Other Publications.—Twelve issues of The Journal of the Florida Medical Association have appeared since the last report, with an increased number of pages devoted to scientific information, and, because of economic problems, an ever decreasing number of pages devoted to advertising. Despite this editorial and advertising percentage change, The Journal continued to function effectively at no loss of money for the Association.

An effort has been made to interest more people in contributing to The Journal and, it is hoped, in reading the information in The Journal, by devoting entire issues to one county society's scientific articles, by circularization of the county medical society presidents, requesting that they bring any society problems to the attention of the state through letters to the editor, and by requesting specific special interest groups to discuss problems in diagnosis and treatment.

Postgraduate Education. — Twenty-six postgraduate courses have been approved to date this year. This would indicate a healthy condition in this area. There have been no controversial mattesr that justified a meeting of the Committee. The membership of the Committee was polled in December and no requests for such a meeting were received.

Research. — The Committee has screened two applications for funds for research projects. No recommendations for research grants were made. The Committee recommended additional funds be granted for continuation of one previously approved project.

Scientific Work. — The Committee met in May, September and December 1963 to plan the scientific program for the May 1964 annual meeting. The change in format suggested and approved by the Board of Governors was implemented.

Recommendations:

That the whole of the state Association, through its administrative offices at the state and county levels (a) encourage active participation from the membership in the scientific aspects of The Journal, (b) use more fully the pages of The Journal to explain the functions of its many committees and council activities, and (c) utilize The Journal more fully to present the problems of the Association and the efforts being made to solve these problems, so that we may have a better educated membership, and, in turn, a membership with common purpose.

"The Reference Committee moves the adoption of the Report of the Council on Specialty Medicine with the exception of item 3 'Committee on Pathology' which should be deleted in accordance with the request of the Committee on Pathology.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections; motion carried.

Council on Specialty Medicine

EMMET F. FERGUSON JR., *Chairman*

Council:

The Council on Specialty Medicine held three meetings during the Association's administrative year, 1963-64. Members of the Council served as consultants to various groups when requested and found these contacts an excellent stimulus when reported back to the Council. The Council on Specialty Medicine serves in a liaison capacity in working with specialty groups; specialty group members should bring their problems before the Council for discussion and mediation rather than take individual action. In effect, the Council on Specialty Medicine acts as a forum for members of the Association. The Council maintains an advisory committee to work in close liaison with the Committee on Scientific Work on the annual Scientific Program. We feel this will gradually improve the format of these programs.

The Council endorsed the activities of the county medical societies in establishing voluntary health insurance review committees.

The Council endorses the fine work of the Fee Schedule Committee and the Medical Consultant to the Florida Industrial Commission in implementing the new Workmen's Compensation medical fee program as their objectives are the same as those of the Council.

The Council opposes the recently passed Senate Bill No. 537 permitting the employment of unlicensed M.D.'s who would not otherwise qualify under the Medical Practice Act.

The recommendation that county medical society insurance committees be utilized in the evaluation of claims and administration of the Workmen's Compensation fee schedule was referred to the Board of Governors and, in turn, to the Committee on Fee Schedules for consideration and implementation.

The Committee on Psychiatry endorses the report of the Committee on Mental Health regarding a Department of Mental Health.

Recommendations:

Following careful study and often lengthy deliberation, the Council makes the following recommendations:

1. **The Council recommends to the Committee on Fee Schedules that the Florida Industrial Commission be contacted and asked to clarify the instructions concerning the 1962 Florida Relative Value Studies, as used in the Florida Industrial Commission Fee Schedule.**
2. **That the Fee Schedule Committee and the Florida Medical Association exert their best efforts to see that Florida Statute, as quoted below, is implemented.**

 a. **That a fee schedule should not be considered as a fixed and inviolate schedule of fees, but only as a guide or standard by which to judge the fairness of a doctor's charges.**

 b. **That if there is substantial deviation from the fee schedule, adequate provision should be made for review of the charges by a committee of local physicians and then by a board of physicians and officials drawn from all sections of the state.**

Section 440.13 (3)(a) Florida Statutes provides:
"All fees and other charges for such treatment or service shall be limited to such charges as prevail in the same community for similar treatment of injured persons of like standard of living, and shall be subject to regulations by the commission, who shall adopt schedules of charges for such treatment or services."

3. **That approval be given to the following resolutions:**

 a. **Whereas, There is an apparent oversupply of General Surgeons in Florida and in the United States as a whole, and**

 Whereas, The American College of Surgeons in a recent survey of all the membership, as reported in the "Bulletin of the American College of Surgeons," Volume 48, November-December 1963— Number 6, recognizes the imbalance and oversupply, therefore be it

 RESOLVED, That the Florida Medical Association requests of the American Medical Association that the Council on Medical Education and Hospitals be requested to develop a program to inform the newly graduated physicians of American medical schools of the supply and demand in the specialty fields in the United States.

 b. **Whereas, The various acts of the legislature allow for the "treatment" of the human body by any group, without regard for the "adequacy" of their training, and**

 Whereas, This has given cultist groups a pseudo-prestige" cnd therein misleads the public; therefore be it

 RESOLVED,That the Florida Medical Association review all medical practice acts for the purpose of proposing appropriate corrective legislation.

In addition to the Council recommendations, several Committees made individual recommendations:

1. Committee on Internal Medicine. — Continued careful watchdog scrutiny of federal, state and private fee schedules to avoid reductions and failure to pay for quality service; continuing evaluation of 1962 Relative Value Studies to avoid inevitable obsolescence.

2. Committee on Ophthalmalogy and Otolaryngology. — There was universal dissatisfaction in the Ophthalmology section with the handling of Workmen's Compensation fees. It was decided that a conversion factor of 5

most nearly represented the usual fee and it was agreed by all to submit Workmen's Compensation fees on this basis. The Otolaryngology section is still actively working on the hearing aid program for the State of Florida.

3. Committee on Orthopedics. — The Florida Orthopedic Society wishes to state that we are unhappy with the Workmen's Compensation fee schedule as administered by the Florida Industrial Commission. We wish to emphasize that we are not trying to act independently, but rather in cooperation with the Florida Medical Association.

4. Committee on Surgery. — The Florida Association of General Surgeons feels strongly that changes of conversion factors from section to section are not in keeping with good harmonious relations in medical care. We deplore the adoption of any medical fee schedule by any governmental or social agency which is inequitable to one section of medical practice as compared with another.

"The Reference Committee considered Resolution 64-7 and recommends approval of this resolution as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections; motion carried.

Resolution 64-7

General Practice

Orange County Medical Society

Whereas, A large segment of the medical profession in the United States is made up of physicians engaged in general practice, and

Whereas, The number of graduates of medical schools entering general practice has been steadily decreasing, and

Whereas, Surveys and polls continue to emphasize that many Americans want to be cared for by general practitioners, and

Whereas, The American Medical Association in session assembled in June 1963, recognized the "importance of the general practitioner as an essential component of American Medicine" and expressed a need for "an adequate number of medical school graduates selecting general practice for their medical careers," and

Whereas, The AMA House of Delegates resolved to "instruct its Board of Trustees to utilize all facilities at its command to

(a) inform the medical schools of the shortage of general practitioners, and request their cooperation in exposing medical students to general practice by lectures, preceptor programs, and clinical instructors who are practicing general practitioners, and

(b) inform the constituent state medical associations of the need to emphasize general practice training and to ask these associations' members to encourage students to go into general practice,"

now therefore be it

RESOLVED, That the Florida Medical Association House of Delegates likewise recognize this problem and implement to the best of its ability the intent of Resolution 68 passed by the AMA House of Delegates, and further be it

RESOLVED, That the Florida Medical Association Board of Governors initiate and/or supervise the remedial measures to be taken to correct this serious problem facing the American public, namely, the critical shortage of general practitioners to serve the public.

"The Reference Committee recommends disapproval of Resolution 64-10, Establishment of Third Florida Medical School, by the Hillsborough County Medical Association, but recommends that the Florida Medical Association establish a committee for long range study of this subject.

"Mr. Speaker, I move the disapproval of this resolution."

No discussion; no objections, motion carried.

"The Reference Committee recommends approval of Resolution 64-18 and the amendment to this resolution as presented to the First House of Delegates.

"Mr. Speaker, I move the adoption of this resolution and amendment."

No discussion; no objections, motion carried.

Resolution 64-18

Need for Family Physicians

Marion County Medical Society

Whereas, The Physicians Placement Service of the Florida Medical Association has had on hand during the past year 257 requests for family physicians out of a total of 772 for all physicians, and

Whereas, It is becoming increasingly more difficult to fill the requests for family physicians, and

Whereas, Future needs for family physicians may become even more acute, unless appropriate measures are taken, as the population of Florida increases, and

Whereas, It is the first and primary obligation of medical schools to educate physicians to render medical services commensurate with the needs and wishes of the people, therefore be it

RESOLVED, That the Marion County Medical Society in regular session on April 28, 1964, requests the House of Delegates of the Florida Medical Association to call this great need for more family physicians to the attention of the deans and faculties of the medical schools, to the Boards of Trustees of the Universities with medical schools, and to all incumbent members and future members of the 1965 legislature and to request the medical schools in this state to offer a general rotating internship at each school, and further be it

RESOLVED, That the Florida Medical Association delegates to the American Medical Association be instructed to support this policy on a national level in the House of Delegates of the AMA, and to instruct the AMA officers and Board of Trustees in the need for true implementation of such a policy and not mere notification of the various medical schools.

"Mr. Speaker, I move the adoption of this entire report as amended."

No discussion; no objections, motion carried.

Dr. Marion thanked the members of his committee: Drs. G. Dekle Taylor, Walter E. Murphree, Clyde O. Anderson and Scottie J. Wilson.

REPORT OF REFERENCE COMMITTEE NO. II

Public Policy

Dr. William J. Dean, Chairman: "Mr. Speaker, Mr. President, and Members of the House of Delegates: Your Reference Committee on Public Policy gave careful consideration to items referred to it and makes the following report:

"The Reference Committee considered the report of the Council on Allied Professions and Vocations and recommends that it be approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections; motion carried.

Council on Allied Professions and Vocations

THOMAS C. KENASTON SR., *Chairman*

Council:

Subsequent to the Association's 1963 annual meeting and as of the date of this report, the full Council held one formal meeting on September 8, 1963. The recommendations included in this report are Committee recommendations only and have not been considered nor acted upon by the Council.

During the past year some Committees of the Council have shown excellent progress, but others have accomplished little because of the lack of counterpart liaison committees in the profession or vocation and for various other reasons. In general, there has been a marked increase in contacts and liaison activities during the past year over the preceding year. The expansion, in 1963, of the Council's former committees-of-one to regular standing committees of five was advantageous in that it provided geographically more accessible liaison contacts and more effective committee program planning and implementation. In summary, it is believed that the Council, during the period covered by this report, well justified its existence.

Committees:

Dentistry. — The Committee was represented at the Council meeting on September 8, 1963, by James G. Robertson, M.D. Meetings have been held between the Committee and the Medical Liaison Committee of the Florida State Dental Society to discuss mutual programs and problems between the two professions.

Law.—The Committee has prepared a proposed interprofessional medicolegal code which has been submitted for consideration through appropriate policy levels for eventual adoption by the Florida Medical Association and The Florida Bar. The Committee also has studied carefully the legal status of nurses with references to intravenous administrations and has submitted recommendations to other committees, councils and organizations concerned.

Medical Assistants. — The chairman attended the Tenth Annual Meeting of the Florida Medical Assistants Association May 24-26, 1963, in Orlando, and the Council meeting on September 8, 1963 in Miami. Syllabi for the two new study courses in the FMAA educational program entitled "The History of Medical Terminology" and "Law and Economics in Medical Office Administration" were presented through the Council to the Board of Governors which approved the two syllabi on September 20, 1963. It is felt that the Florida Medical Assistants Association is a well motivated group which is worthy of continued Florida Medical Association support and the support of the county medical societies of its county chapters in the areas where they exist.

Medical Technologists. — Members of the Committee have attended the annual and semi-annual meetings of the Florida Division of the American Society of Medical Technologists by invitation. Members of the Committee have worked with the technologists and representatives of the Florida Department of Education in developing schools for "laboratory assistants" and will act as consultants with the technologists in this program to train certified laboratory assistants. The serious shortage of laboratory personnel throughout the state makes this program essential.

Nursing. — Activities of the Committee on Nursing have centered on establishing and maintaining better liaison between the various nurses' organizations, in particular the Florida Nurses Association and the Florida Medical Association. We have met twice as a Committee with a like committee of the Florida Nurses Association and there has been a frank exchange of views in areas of mutual concern. Further meetings are scheduled and we are pleased with the progress being made toward closer liaison and better rapport.

A member of your Committee has continued to serve on advisory committees to the State Department of Education for Health Occupations and Practical Nurse Education and for the "Associate Degree" Nurse Education Program. These advisory committees are particularly active and give opportunity for increased liaison with other nursing groups and health occupations.

In February, on invitation of the president of the American Medical Association, the chairman attended a three-day jointly sponsored national conference for professional nurses and physicians which was held in Williamsburg, Va. The title selected for this conference was "Medical and Nursing Practice in a Changing World" and it gave opportunity for detailed discussion of areas of mutual concern to the two professions. This conference was considered to be highly successful and it is probable that such conferences will be held yearly hereafter.

The Committee recommends continuation of the close liaison which has been established with the nurses' organizations in order to maintain frank discussions of all areas of mutual concern or possible conflict. In conjunction with the Committee on Law, the Committee also studied the problem of the legal status of nurses with respect to intravenous administration. No official body of the American Medical Association has yet rendered an opinion as to the extent to which nurses may do venipunctures or administer intravenous medication. A physician may, and frequently does, delegate certain of his functions to nonmedical personnel. The dividing line between procedures that may be lawfully so delegated and those that may not, is not clearly demarcated. Whatever functions may be delegated, however, must be exercised under the direction and supervision of the physician and he must assume responsibility, in part, for any untoward results. The administration of intravenous therapy appears to constitute more than a nursing procedure. Some authorities claim that it constitutes the practice of medicine and if a nurse does undertake the procedure, she does so not because she is a nurse but because she acts as an agent of one who is lawfully authorized to do the administering. Intravenous therapy is one of many acts formerly performed exclusively by physicians which are now delegated to nurses, technicians or others. Essentially the requisites

are that the treatment be prescribed by a physician and that the nurse be competent to administer it.

Recommendation:

It is the opinion of the Committee that a resolution should be adopted similar to a statement adopted in 1954 by the California Medical Association. Accordingly, the following resolution is proposed for adoption by the Florida Medical Association: that the House of Delegates go on record as approving the intravenous administration of fluids by competently trained, registered, professional nursing personnel, under medical supervision, and recommending introduction of instruction in intravenous technique among practicing nurses and into schools of nursing.

Pharmacy. — Informal meetings have been held with representatives of the Florida State Pharmaceutical Association to consider mutual problems. The chairman answered various requests during the year for information in the field of medicine and pharmacy. Representatives of the Committee attended the First National Congress on Medicine and Pharmacy in Chicago March 12 and 13, 1964, and will participate in other programs of pharmaceutical groups meeting in Florida. It is proposed that a joint meeting be held in the near future between the Committee and the Interprofessional Committee of the Florida State Pharmaceutical Association to consider, among others, the following matters:

(a) Formulation and adoption of a joint State medical-pharmaceutical code of understanding.
(b) Holding a Florida State Congress on Medicine and Pharmacy.
(c) The establishment of a referral mechanism to handle complaints and problems between physicians and pharmacists.
(d) Continued discussion of areas of conflict regarding physician-owned pharmacies.

Physical Therapy. — Some liaison has been maintained during the year through the Association's Executive Office with officers of the Florida Chapter, American Physical Therapy Association. We adopted for our annual project, the preparation of a resume review manuscript covering current developments in Bioelectronics which has been forwarded to the Editor of The Journal with recommendations that it be published.

Recommendation:

That program committees from county to state levels give consideration to presenting authoritative speakers, on occasion, who will review current developments in these fields. Our survey reveals this to be totally lacking at the county level, and at the state level, even though annual applications have been made for appearances on the annual programs, they have been invariably denied. We believe that this field henceforth will occupy an integral part of medical practice and will therefore need attention.

Podiatry. — During this past year there has been an attempt to correlate various forms of informative letters and information relative to the situation of podiatry nationally, as well as locally, to determine the policy from the standpoint of state level. At best it might be said that this is still under consideration as far as the American Medical Association and the American Academy of Orthopaedic Surgeons are concerned. It seems to be unique that podiatry represents the only group of ancillary services to medicine desiring hospital privileges who have been resisting accreditation of their schools. Any policy which will be established on a state level will have been something that is done prior to the time that the national situation has been clarified; therefore, this has not been done during this past year.

Veterinary Medicine. — In October 1963 the Association's president-elect and an executive staff member, took part in the 1963 annual meeting of the Florida State Veterinary Medical Association.

During the past year, three of the five members of the Committee have participated jointly with members of the veterinary medical profession in their areas on cooperative research projects. A jointly sponsored exhibit describing these projects will be presented at the Association's annual meeting in May 1964, and it is planned that the exhibit also will be shown at the 1964 annual meeting of the State Veterinary Medical Association. Through these research activities, it is felt that excellent liasion has been established.

X-Ray Technicians. — During the past year the Committee held two informal meetings by mail. In September 1963, and again in February 1964, the members were canvassed for any matters to come before the Committee. Replies from members indicate that there are no activities in their portions of the state which require consideration by the Florida Medical Association.

"The Reference Committee considered the report of the Council on Voluntary Health Agencies and recommends that it be approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections; motion carried.

Council on Voluntary Health Agencies

MASON ROMAINE III, *Chairman*

Council:

Since the Council on Voluntary Health Agencies has no functioning committees as such, itself operating in effect as a committee, the following summary of its activities and recommendations will constitute the council's complete report.

Official Council meetings were held June 15, 1963, and February 1, 1964, with a subsequent meeting planned for May or June 1964.

Early in 1964, the programs of the eight statewide voluntary health agencies officially recognized by the Association were re-evaluated, and no grounds were found for discontinuance of recognition for any individual agency. The following organizations currently are recognized:

Arthritis and Rheumatism Foundation, Florida Chapter
Florida Society for the Prevention of Blindness
American Cancer Society, Florida Division
Florida Society for Crippled Children and Adults
Florida Heart Association
Florida Association for Mental Health
The National Foundation
Florida Tuberculosis and Health Association

At the February meeting, a conference was held with representatives of the Leukemia Society, Inc., relative to that organization's application for recognition, which is under advisement. Applications from four other agencies also are being studied. Recognition of no further agencies is recommended at present.

Considerable time was spent by the Council in review of the ten criteria utilized for recognition. Finally, it was the Council's decision to recommend the addition of an eleventh criterion requiring medical representation on an agency's board of directors.

Efforts were continued to secure the creation by the Secretary of State of an advisory committee on the voluntary health organization registration law. For several reasons beyond the control of the Council or the Association, this was not accomplished during the past year. This matter is being pursued through all appropriate channels, with new approaches possibly indicated.

Concern was expressed relative to the apparently increasing amount of mail solicitation of funds by agencies not necessarily classified as voluntary health agencies under Florida law and not registered with the office of the Secretary of State. This subject was referred to other appropriate Committees and Councils of the Association for study and recommendations.

Another matter considered by the Council was criticism sometimes expressed within the profession pertaining to unsolicited publicity given physicians active in com-

munity voluntary health organization activities. A resolution was adopted which is included in the recommendations.

The Council continued its cooperation with the Florida Institute for Continuing University Studies in assisting to further that agency's efforts to provide educational courses for voluntary agency personnel through the annual Institute for Voluntary Health Agencies. The untimely death on February 3, 1964, of assistant professor David Legate, who ably coordinated these programs since their inception several years ago, was noted with sadness. A letter was written to F.I.C.U.S. President Dr. Myron Blee expressing the Council's willingness to assist in providing these programs in the future.

With the knowledge that to succeed, the Association's program in this entire field must be implemented on local levels, much thought and effort were given to establishing liaison with county medical societies. Two counties, Orange and Duval, are carrying out "pilot" programs of liaison with local voluntary health agencies and it is hoped future guidelines will be developed for utilization by other county medical societies.

During the year, liaison was maintained with the many official and voluntary organizations concerned with the voluntary health movement. A significant step was taken by the major voluntary agencies in forming, in June 1963, a "Florida Voluntary Health Agencies Coordinating Committee." Establishment of such a committee had been encouraged by the Council for some time. It is now a functioning reality. Excellent liaison has been obtained with the American Medical Association Council on Voluntary Health Agencies through the chairman's membership on that body.

Finally, the Council gave consideration to formulating its objectives and purposes beyond those stated in the Association's By-Laws.

Recommendation:

Adoption of the following resolution:

Whereas, The favorable image of the physician in the eyes of the public is of concern to all the physicians of the state, and

Whereas, The component county medical societies, the Florida Medical Association and the American Medical Association are exerting both considerable energies and monies to accomplish this, and

Whereas, Various physicians are actively involved in community health-related activities and voluntary health organizations through which these physicians achieve unsolicited publicity, therefore be it

RESOLVED, That this publicity is to be desired and encouraged and is not to be considered as advertising by the physician, and be it further

RESOLVED, That the Public Relations Officer of the Florida Medical Association and the public relations committees of the county medical societies be encouraged to assist in getting all publicity possible from these activities.

"The Reference Committee considered the report of the Council on Medical Services and recommends the adoption of this report with the exception of recommendation 11 on page 29 of the Handbook which should be amended to read '. . . that whole blood be immediately available to all hospitals.'

"Mr. Speaker, I move the adoption of this portion of the report as amended."

Motion was seconded from the floor.

Dr. Charles R. Sias, of Orange: "This Amendment changes only one word. It changes 'in all hospitals,' to 'to all hospitals.' The Maternal Health Committee feels very strongly about this word. I cannot give you statistics, but several lives were lost last year because blood was not immediately available. I move that this recommendation No. 11 not be amended."

Amended motion was seconded from the floor.

Comments were made by Dr. Dean, Dr. Thomas D. Weaver of Lake; Dr. M. Eugene Flipse of Dade; Dr. Reddin Britt of St. Johns, in opposition to the amended motion.

The Speaker called for a vote on Dr. Sias' motion to amend the Reference Committee report.

The amendment was defeated by a majority vote.

The Vice Speaker asked for any further discussion on the original motion.

Dr. Leo M. Wachtel, Duval County: "I am speaking with reference to recommendations 13 through 18. I realize the legislature will meet before this body meets again. We feel that the setting up of a separate department of mental health is an unwise and expensive step for the state to take. Inasmuch as the state legislature will meet before we have the chance to meet again, I move that recommendations 13 through 18 be referred to the Board of Governors for review with the power to act as far as legislation is concerned, in place of the report of the Reference Committee."

Seconded by Dr. James T. Cook, of Jackson-Calhoun.

A general discussion of the subject followed, in which Dr. Dean, Dr. Robert E. Zellner, Dr. Charles R. Sias of Orange, and Dr. Walter E. Murphree of Alachua, participated.

Dr. Leo M. Wachtel, Duval: "I would like to offer a substitute motion for the whole: That recommendation No. 13 only be referred to the Board of Governors for review and action."

The substitute motion was seconded.

Dr. Albert C. Jaslow of Dade and Dr. William M. C. Wilhoit of Escambia spoke in opposition to the substitute motion and Dr. Weaver of Lake spoke in favor of it.

The substitute motion carried.

The main motion, as amended, carried.

Council on Medical Services

CHARLES R. SIAS, *Chairman*

Council:

Official Council meetings were held September 15, 1963, and March 1, 1964. The former meeting was devoted primarily to review and planning of individual committee programs. The latter meeting was given over to consideration of the annual reports of the Committees and to adoption of Council recommendations. It is the feeling of the chairman that one of the major accomplishments of the year was the development of a better understanding and rapport among the Council chairmen concerning

each other's programs, as well as those programs of mutual responsibility.

For the purposes of clarity and organization in this report, each Committee's recommendations which were approved and adopted by the Council are shown immediately following the brief summary of the Committee's activities. All recommendations are numbered consecutively.

Committees:

Aging. — During the past year the Committee has reviewed its past activities for the purpose of more clearly defining its functions and objectives. It was noted that the Association By-Laws do not define these functions and objectives and that there was a need for clarification to avoid possible duplication of effort by other Committees.

It was agreed that the Committee's basic objective is the rendering of good medical care to the aging. This total concept should include quality of care and types of service, as well as nursing home programs, home care programs, and economic problems. The Committee felt that it should act as a clearing house for recommendations from the various groups concerned with aging and also follow up on implementation of these recommendations at the local county level.

The Committee recommendation that it be represented by at least one of the Florida Medical Association's two official voting representatives on the Florida Joint Council on Health of the Aging was approved by the Board of Governors in September 1963.

It cosponsored, with the Committee on Mental Health, a conference in November 1963 dealing with the feasibility of removing nonpsychotic aged patients from the state mental hospitals and placing them in nursing homes in their local communities.

Blood. — During the past year the Committee has reviewed a county-wide study of blood bank services by the Brevard County Medical Society and has adapted it for use by any county medical society in the state. It is the opinion of the Committee that community blood banks under local control are preferable and that it would be best for all hospitals in the state to utilize the same type of blood banking service.

Recommendation:

1. That county medical societies encourage the establishment of community blood banks in each county or region which does not have such a facility.

Child Health. — The role of this Committee during the past year has demonstrated increased emphasis on its advisory capacity and close cooperation with the State Department of Education and the State Board of Health.

Most notable in the field of education is the development of a curriculum for health education in the public school system. This curriculum will include education on the effects of smoking as specified in last year's resolution of the House of Delegates. This program is ready for the fall semester. With the State Department of Education, a Governor's Council on Fitness and Health has been established. The liaison member from the State Department of Education, Mr. Zollie Maynard, attends all of our meetings and is very cooperative in his effort.

As advisors to the State Board of Health, we have been asked to assist in revising the Driver's Training Physical Form. We also have advised in the local execution of the birth certificate follow-up immunization program. This program has been generally directed toward education to receive these immunizations through the family physician. We have congratulated the Florida State Dental Society on developing with the State Board of Health "A Guide: Design for Teaching Dental Health" now being used in the public school system. In cooperation with the Committee on Hearing we are working out a program of hearing screening, administered by Dr. L. L. Parks of the State Board of Health.

Our participation in the implementation of the battered child law and the production of a form to be used throughout the state in reporting cases of "battered children" is in its formative phase and we pass this on to the next committee.

Recommendations:

2. That a tentative statewide meeting in the fall of 1964 between county school superintendents, public health officials, and representatives of the Florida Medical Association, be approved and encouraged.

3. That participation by representatives of the Florida Medical Association in a Governor's Council on Fitness and Health, if and when confirmed, be approved.

4. That we continue to encourage each county medical society to have as part of its public health committee, a school health advisory physician to assist local school and public health officials.

Emergency Medical Service.—The principal activity of this Committee has been its role as Advisory Committee to the Selective Service System for Florida. We have received approximately fifteen requests for evaluation of essentiality of physicians. In each case, these have been forwarded to the local county society and its opinion forwarded to the State Selective Service Committee.

Recommendation:

5. That each county medical society Emergency Medical Service Committee, or its equivalent, assist the state committee in evaluating the essentiality of physicians in the local community when such is requested.

Hearing. — This Committee has been working with Dr. L. L. Parks of the State Board of Health in planning the school hearing testing program for the State of Florida, recommended by our Committee last year and passed by the House of Delegates. When hearing difficulties are found, parents will be advised to contact their family physician and indigent cases will be reported to the county medical society and appropriate local agencies for assistance. When the magnitude of the indigent problem has been ascertained, assistance will be requested through the Medical Advisory Committee to the Hospital Service for the Indigent Program. It is our hope that this program will be started in September 1964.

The Committee also has been attempting to encourage Kiwanis clubs throughout the state in establishing a program to obtain hearing aids for the indigent hard of hearing. In a related area, the Committee has been studying the ethical standards of the Florida Hearing Aid Association with a view toward coordinating these standards with those of the American Speech and Hearing Society. In cooperation with the Florida Society of Ophthalmology and Otolaryngology the Committee plans an exhibit of the Temporal Bone Bank from the University of Chicago and a hearing testing booth at the annual meeting of the Association.

Indigent Care. — During the past year the Committee has studied the Association's policies pertaining to physicians' services and hospitalization of the indigent. The Committee met in October 1963, with the Advisory Committee to the Hospital Service for the Indigent Program concerning operation of the new MAA program in Florida.

In cooperation with the Bureau of Special Health Services of the State Board of Health, the Committee initiated preparation of a wall chart designed to present a composite summary of health care programs available in Florida to eligible indigent persons. The Committee also plans to cosponsor with the State Board of Health an exhibit on indigent care at the Association's annual meeting.

Recommendations:

6. That the Association's statement of policy regarding availability of physicians' services to indigent persons be re-affirmed and that county medical societies be requested to re-examine their practices with reference to care of indigent persons. It is further recommended that an additional sentence be added to the Association's policy to read "That where care is provided in the doctor's office he is then entitled to a fee for reimbursable costs, excluding services."

7. That county medical societies establish such criteria on a local basis in order to meet the needs of their communities and that the American Medical Association guide

for physician services to the indigent entitled "A Guide to Policy Statements" be utilized.

8. In regard to the Medical Assistance for the Aged (MAA) Program:

1a) That expenditures for needed health care be considered as one of the requirements, in determining financial eligibility for public assistance.

1b) That greater liberalization of resources (other than income) be allowable to prevent the possibility of permanent pauperization of MAA recipients.

(c) That in determining eligibility for benefits under the MAA program, the difference between an applicant's basic requirement income and actual income over a period of one year be considered.

9. That the previous recommendation be reaffirmed that physicians in those counties not participating in the Hospital Service for the Indigent program be requested to explain the purposes of the program to and encourage their county commissioners to have their counties become participating counties, in that county financial participation is a fundamental requirement for efficient and economical operation of a tax-supported health care program.

10. That the previous recommendation be reaffirmed regarding review of hospital admissions of the needy paid for through the use of tax funds, and it is recommended further that such review be incorporated into the activities of hospital staff utilization committees.

Labor. — The Committee has continued to pursue the adoption by organized labor of a policy authorizing the formation of a Joint State Medical - Labor Liaison Committee. Due to the complexity of organized labor in Florida, some delay has been encountered. The Committee plans to undertake renewed efforts and possibly new approaches during the coming year to achieve this objective which already has been approved by the Association's House of Delegates.

Maternal Health. — The Committee has continued to conduct the Florida Maternal Mortality Survey and has reported its findings through various channels. The Committee also has cooperated with the State Board of Health in sponsoring the annual obstetric/pediatric seminar. Study also has been maintained of existing and needed legislation in the field of maternal health.

Recommendations:

11. A number of deaths were attributed in 1963 to the failure of hospitals to have whole blood on hand, so it is recommended that whole blood be immediately available to all hospitals.

12. That efforts be continued for the passage in the Florida Legislature of bills for the protection of privileged communication in scientific studies.

Mental Health. — During the year the Committee has continued to work cooperatively with private and governmental groups dealing with the general area of mental health. Close liaison with the Florida Psychiatric Society has been firmly established. The annual conference of state mental health leaders was held in November 1963, along with a state conference cosponsored with the Committee on Aging on problems of nonpsychotic aged patients currently in the state mental hospitals. Advice and assistance were provided to the new unit for psychotic children at the University of Florida, the State Board of Health and the Committee on Mental Health of the Florida Legislative Council. The Committee also has represented the Association on the Advisory Council of the Florida Mental Health Planning Program and the chairman has served as a member of its Steering Committee.

Recommendations:

13. The establishment of a Department, or Division, of Mental Health under the direction of a qualified psychiatrist. Such Department should include state mental hospitals; adult and children's psychiatric services, either in-patient or out-patient; community mental health centers; diagnostic and treatment facilities for the mentally retarded, either in-patient or out-patient; hospitals or clinics for rehabilitation of alcoholics, and all state services and facilities whose primary orientation is related to the area of mental health and treatment of the mentally ill. Every effort should be made to utilize personnel who are presently employed in, or responsible for, whatever divisions would be affected by such reorganization.

(Referred to the Board of Governors for review and action)

14. Florida Medical Association cosponsors with the Florida Association for Mental Health a legislative conference for state legislators, to present and further explain legislative objectives of the organizations, providing, however, that the objectives of both organizations are in full accord, and that the FMA not be committed to any financial obligation.

15. Florida Statutes relating to mental health and mental hygeine be reviewed and revised as necessary.

16. Immediate provisions in the Florida Statutes for emergency, involuntary admissions to hospitals of persons suspected to be psychotic.

17. Physicians be encouraged to participate actively and cooperate with other community leaders, in community mental health planning and services, particularly utilizing the structure of the county medical society as a means of representation and participation.

18. Physicians actively participate and cooperate as medical members of committees appointed by county judges to inquire into the mental or physical competency of persons who are alleged to be physically or mentally incompetent.

Public Health. — The recommendation of this Committee that the birth certificate follow-up immunization program be made available state-wide was approved by the Board of Governors in May 1963. The primary effort of this program is education to receive these immunizations through the family physician. The Committee was represented on the Florida Coordinating Council for Tuberculosis. Recommendation of a limited oral cytology study sponsored by the Florida State Dental Society and the State Board of Health was approved by the Board of Governors in September 1963.

Recommendation:

19. That implementation of the new law authorizing bequeathing of bodies or parts of bodies for scientific purposes (Chapter 736.18, Florida Statutes) be stimulated primarily through the Association and its appropriate Committees.

Rural Health. — In pursuance of its recommendation in 1963 that each county medical society appoint a rural health committee or a member interested in this field, the Committee reported that these appointments have been accomplished in all of the 41 component societies. The Committee continued to supervise the Association's participation as a member organization in the joint Florida Committee on Rural Health. Various meetings on the state and national levels were attended by the chairman.

Vision. — During the past year, the Committee continued its two major activities of promoting medically supervised eye screening programs in public schools and glaucoma screening in the state's adult population above 40 years of age.

"The Reference Committee recommends that Resolution 64-1 be amended to read '. . . the American Pharmaceutical Association be requested to institute a program of labeling every dispensed prescription drug with the expiration date which appears on the original package under the requirements of the Food and Drug Administration.'

"Mr. Speaker, I move the adoption of this resolution, as amended."

No discussion; no objections; motion carried.

Resolution 64-1

Labeling of Drugs as to Expiration Date
Hillsborough County Medical Association

Because certain antibiotics after periods of storage show breakdown products that may cause toxic responses when ingested, and because the shelf life of most drugs is unknown to the lay public and to many physicians, be it

RESOLVED, That the Florida Pharmaceutical Association and the American Pharmaceutical Association be requested to institute a program of labeling every dispensed prescription drug with the expiration date which appears on the original package under the requirements of the Food and Drug Administration.

"The Reference Committee recommends disapproval of Resolution 64-11, Heart Clinics. This disapproval was recommended in the best interest of the Florida Medical Association since it is not felt that a need for such heart clinics currently exists.

"Mr. Speaker, I move that Resolution 64-11 not be adopted."

No discussion; no objections; motion carried.

The Vice Speaker ruled that consideration of Resolution 64-12 was not necessary in view of the previous motion on the Council on Medical Services Report.

"The Reference Committee recommends disapproval of Resolution 64-14 since it is contrary to the previously approved report of the Council on Allied Professions and Vocations.

Opposition to the motion of the Reference Committee was expressed by Dr. Louis P. Brady of Orange and Dr. Anthony C. Galluccio of Broward. Two motions to approve Resolution 64-14 were ruled out of order by the Vice Speaker.

The motion of the Reference Committee to disapprove resolution 64-14 was defeated.

A motion to refer this resolution to the Board of Governors for further study was ruled out of order by the Speaker.

After considerable discussion a motion to reconsider the previous action was defeated.

Dr. Brady, Orange: "I move that Resolution 64-14 introduced by the Polk County Medical Association (with the correction of the word 'adequately' to 'inadequately') be approved.

Motion was seconded.

A discussion followed in which Dr. Ben C. Storey of Brevard and Dr. Flipse of Dade participated.

A motion to table the motion on the floor was ruled out of order by the Vice Speaker as you cannot table an amendment to a motion.

Dr. Arthur J. Moseley, Polk: "I move to withdraw the Resolution 64-14 on behalf of the Polk County Medical Association."

A vote was taken to determine if there was a two-thirds majority in favor of allowing Polk to withdraw the resolution.

The motion to withdraw the resolution was defeated.

Dr. Thomas S. Edwards, Duval, moved that the matter be tabled for further consideration next year.

Motion was defeated.

The motion to adopt Resolution 64-14 carried.

Resolution 64-14

Podiatry
Polk County Medical Association

Whereas, The Florida Medical Association, following the lead of the American Medical Association, has specifically announced recognition of Podiatry as a sister profession, to be given appropriate prerogatives and privileges, and

Whereas, This action has been found to be inadequately justified, therefore be it

RESOLVED, That the Florida Medical Association withdraws such approval and recognition.

Dr. Dean moved for adoption of the entire report as amended.

Motion carried.

Dr. Dean thanked the members of his Reference Committee: Drs. William M. C. Wilhoit, Louis C. Murray, Francis N. Cooke and Banning G. Lary.

REPORT OF REFERENCE COMMITTEE NO. III

Finance and Administration

Dr. George S. Palmer, Chairman: "The Reference Committee on Finance and Administration has considered each of the items referred to it, and desires to present the following report. The Reference Committee's recommendations on each item will be submitted separately and I respectfully suggest that each item be acted upon before going to the next.

"The Reference Committee recommends approval of the Board of Governors report and wishes to commend the Board especially on the efficient manner in which it has handled the financial affairs of the Association.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections; motion carried.

Report of the Board of Governors

WARREN W. QUILLIAN, *Chairman*

The Board of Governors held four formal meetings during the Association's administrative year. They were held on May 19, 1963; September 19-20-21, 1963; January 12, 1964, and April 4-5, 1964. Two meetings were held by conference telephone calls to consider urgent matters on May 29, 1963 and November 11, 1963. If it is necessary to hold another meeting prior to the Annual Meeting, it will be covered in a supplemental report and presented at the first meeting of the House of Delegates on May 7, 1964.

The continuing growth of the Association and its activities has brought with it increasingly heavy responsibilities and demands upon the time of your officers, members of the Board, and the members, especially the chairmen, of councils and committees. The physicians who so willingly serve in these highly significant but often thankless positions at great personal sacrifice are truly dedicated. Every member of the Association owes these men and women a heartfelt vote of appreciation for their personal and collective contributions to our profession during the past year. To this the chairman adds his deep gratitude for the privilege of having been associated with them.

MAJOR ACTIVITIES

ANNUAL MEETING. — The Board approved the program and schedule for the 1964 Annual Meeting submitted by the Committee on Scientific Work. The scientific program again this year will be presented in cooperation with a number of the special interest groups. Six scientific section presentations will be made during the Annual Meeting. The Board further authorized for the second year three special exhibit visitation awards to increase attendance at the Annual Meeting and exhibit visitation. This being the Ninetieth Annual Meeting of the Association, it has been designated as the "Gay Nineties" meeting.

PRESIDENTS' AND SECRETARIES' CONFERENCE. — The Board sponsored the Sixth Annual Conference for Presidents and Secretaries of County Medical Societies on January 25-26, 1964, in Orlando, Florida. Twenty-eight county medical societies were represented at the Conference this year and represented over 95 per cent of the membership of the Florida Medical Association.

FINANCIAL STATEMENT AND BUDGET. — The Board carefully reviewed the financial statement prepared by the Secretary-Treasurer and Executive Director and the auditor's statement prepared by the Association's certified public accountant for the Association's fiscal year, which was the calendar year 1963. In 1963 the Association had an income from all sources of $286,571.00; total expenses incurred, including depreciation and inventory adjustment of $247,804.00, for a net excess of income over expenses of $38,767.00. The Board approved an annual operational budget for the calendar year 1964 in the amount of $263,000.00, plus 5 per cent for reserve and $10,000.00 for reserve toward expenditures for the completed building addition and acquisition of additional property. In compliance with the By-Laws this budget was presented by the Executive Director after consultation with the Secretary-Treasurer, it was reviewed and amended by the Executive Committee, further amended by the Board and was based upon an anticipated income of $285,000.00.

PROPERTY ACQUISITION. — Your Board authorized the purchase of an additional piece of property on the river front adjoining the Association's headquarters building for future needs of the Association and investment purposes.

EXECUTIVE DIRECTOR. — The Board approved a resolution of appreciation to W. Harold Parham, Executive Director, and entered into a five-year renewable contract for his services.

APPOINTMENTS. — On May 19, 1963 the Board appointed Reuben B. Chrisman Jr., M.D., as the AMA delegate to serve on the Board of Governors; Leo M. Wachtel, M.D. as the State Board of Health member of the Board of Governors; approved the President's appointment of Samuel M. Day, M.D. to serve as Public Relations Officer; approved the appointment of the late S. Carnes Harvard, M.D. as the optional member of the Executive Committee; appointed the members of the Committee on Research with Karl B. Hanson, M.D., chairman; appointed Thad Moseley, M.D.. as Editor of The Journal; accepted the Editor's nominations and appointed Charles K. Donegan, M.D., John M. Packard, M.D. and Franz H. Stewart, M.D. as Assistant Editors of The Journal; appointed the Committee on National Legislation of key contact physicians for Florida's congressional delegation; appointed a subcommittee of the Board on Advertising, the selection of members to be left to the prerogative of the President, who appointed Floyd K. Hurt, M.D.; reappointed the subcommittees to the Board on Florida Medical Foundation, Inter-American Relations, Quackery, Venomous Snake Bite, Medicine and Religion; and designated the Executive Committee of the Board to serve as the Committee on Professional Liability Insurance.

COMMUNITY SERVICE AWARD. — The Board reviewed the nominations received from county medical societies and selected the recipient for the A. H. Robins Company Award "For Outstanding Community Service by a Physician," to be presented at the first meeting of the House of Delegates, May 7.

RESOLUTION. — Your Board reviewed the Liberty Amendment referred by the House of Delegates and agreed that no stand be taken on this amendment but to recommend to individual doctors that they act as they see fit. This decision was based upon an opinion of the Association's legal counsel and that of the Board that the provisions of the Liberty Amendment go beyond the provisions of the By-Laws of the Association and the scope of its activities.

MEDICARE. — A Medicare Negotiating Committee was appointed to negotiate a new contract with the Office for Dependents Medical Care for 1963-64. In compliance with the policy of the House of Delegates this contract was renewed for the current year based upon the 1962 Florida Relative Value Studies. The major portion of the contract year has been spent in clarifying the contract and implementing the details of its administration in accordance with the FMA Relative Value Studies. The Board approved the recommendations of this committee as follows:

a. Renewal of the current Medicare contract for the year 1964-65, effective May 1, 1964.
b. The employment of a medical consultant by the fiscal administrator to review all questionable claims before being sent to the FMA Medicare Mediation Committee or county medical societies and to advise the fiscal administrator and the Florida Medical Association.

COUNCIL AND COMMITTEE REPORTS

The Board had the opportunity and the privilege of working closely with the Councils and Committees and exerted great effort in coordinating their activities and implementing the policies of the House of Delegates. The Board on April 5 carefully reviewed and edited all Council and Committee reports to be transmitted to the House of Delegates in the Delegates' Handbook. The complete reports as submitted by the Councils and Committees will be available at the Reference Committee meetings. Specific actions regarding recommendations of the Councils during the year are as follows:

WORKMEN'S COMPENSATION MEDICAL FEES. — The Board approved the new Workmen's Compensation medical fee program, including the Medical Advisory Committee, no published fee schedule approach, and a medical consultant. The Board further commended The Honorable A. Worley Brown, Industrial Commissioner, Thomas J. Bixler, M.D., Medical Consultant to the Florida Industrial Commission, and Henry J. Babers Jr., M.D., Chairman, and members of his Fee Schedules Committee for their efforts in developing and implementing this new program.

COUNCIL ON ALLIED PROFESSIONS AND VOCATIONS. — 1. Amended and approved the recommendation that the Committee on Pharmacy be authorized to prepare an acceptable, standardized prescription form according to criteria adopted by the committee, which would also be subject to approval by the Florida State Pharmaceutical Association.

2. Approved the recommendation that the Committee on Nursing be authorized to hold joint meetings with the new Medical Liaison Committee of the Florida Nurses Association for purposes of improving liaison between the two organizations.

3. Authorized approval be granted to the two new study courses in the Florida Medical Assistants Association educational program.

4. Amended and approved the recommendation that the county medical societies be encouraged to form Professional Liability Committees or assign this responsibility to existing committees of the county medical societies as has been previously requested by the Association.

COUNCIL ON MEDICAL SERVICES. — 1. Approved the recommendation of the Committee on Public Health endorsing the demonstration project by the Florida State Dental Society and the Florida State Board of Health entitled, "A Proposal for Determining the Value of an Oral Cytology Technique for the Early Detection of Oral Cancer."

2. Approved a meeting jointly sponsored by the Committees on Mental Health and Aging to consider need for and feasibility of removing nonpsychotic aged patients from the state mental hospitals and placing them in nursing homes in local communities.

3. Approved the Florida Medical Association's continued participation in the Florida Coordinating Council on TB Eradication.

4. Approved the report of the Committee on Public Health concerning a saturation immunization program through birth certificate follow-up with the provision that these immunizations be administered by private physicians and in cases of indigent patients who do not have a private physician they be given by the county health department, which will keep a record of individual immunizations and if requested by the patient report these immunizations to a private physician.

VOLUNTARY HEALTH AGENCIES. — Approved a recommendation of this Council that the criteria for recognition of voluntary health agencies be amended to require "that an agency applying for recognition have adequate medical representation on its board of directors."

OTHER ACTIVITIES

SPECIALTY GROUPS. — Approved the request for reinstatement of recognition as a specialty group to the Florida Neurosurgical Society.

Amended the criteria for approval of specialty groups by adding additional criterion "that all its members shall be members of the Florida Medical Association."

Approved amendments to the contract between the Florida Medical Association and the specialty groups to which it provides administrative services.

AMERICAN MEDICAL ASSOCIATION MEETINGS. — 1. Considered arrangements to host the AMA 1964 Clinical Session in Miami, November 30—December 3, 1964.

2. Accepted the invitation to participate in the Southeastern States Hospitality Room at the AMA meetings.

OSTEOPATHY. — Reviewed the question of referral of patients to the University of Florida College of Medicine by osteopaths, which was being pursued by the Florida Osteopathic Medical Association with the Board of Control and agreed to oppose such a change in policy.

AUTOMOTIVE CRASH INJURY RESEARCH PROGRAM. — Reaffirmed its approval of the Cornell University Automotive Crash Injury Research Program to be conducted in Florida and agreed to cooperate with this project with the Florida Department of Public Safety, State Board of Health and the Florida Hospital Association.

FMA INVESTMENT PLAN. — Approved the amended Declaration of Plan, Rules and Regulations, Custodial Agreement and Custodial Agent's Authorization Form for the Florida Medical Association Investment Plan which replaces the FMA Investment Trust which has been dissolved, and noted that a member may participate: (1) As an individual with no tax advantage; (2) tax-free pension or profit sharing plan under Public Law 87-792, or (3) through a professional service corporation under Chapter 61-64, Florida Statutes.

FLAMPAC. — Your Board appointed the District Chairmen to the Board of Directors of FLAMPAC in compliance with its Constitution and By-Laws. It approved the FMA Executive Office assisting the organization on a reimbursed basis for educational purposes and in any other reasonable manner which would not jeopardize the Association's tax-exempt status.

PUBLICATIONS. — Approved the text and authorized the publication of three brochures: (1) "Facts About FMA," (2) "A Guide for Malpractice Protection," (3) a Council and Committee handbook entitled, "What Every Chairman Should Know."

AUTO LEASE. — Approved the Autolease Corporation plan for leasing of automobiles by FMA members.

HAITIAN RELIEF. — Commended the participants in the Haiti Hurricane Relief Project for their humanitarian efforts.

NOMINATIONS

CERTIFICATE OF MERIT. — Your Board recommends that Meredith Mallory, M.D., of Orlando be awarded the Association's Certificate of Merit.

COMMITTEE ON MEMBERSHIP AND DISCIPLINE. — As provided for in the By-Laws, the Board of Governors nominates the following physicians for those terms expiring in 1964:

District 3	Edward J. Lauth Jr., M.D., Miami	1968
District 4	Jack Q. Cleveland, M.D., Miami	1965
District 4	Nelson Zivitz, Miami Beach	1968
District 5	W. Wardlaw Jones, M.D., Dade City	1968
District 8	Thomas H. Bates, M.D., Lake City	1968
District 10	Ernest R. Bourkard, M.D., Tampa	1968
District 12	N. Worth Gable, M.D., St. Petersburg	1968

(Additional nominations may be made from the floor of the House of Delegates.)

BLUE SHIELD BOARD OF DIRECTORS. — The Board of Governors reviewed the nominations for the Blue Shield Board of Directors, presented by the Blue Shield Nominating Committee, and from the nominations for each physician directorship the following two were chosen:

Medical District "B"
Three Year Term
John S. Stewart, M.D., Fort Myers
James M. Ingram, M.D., Tampa

Medical District "D"
Three Year Term
Ralph W. Jack, M.D., Miami
Nelson Zivitz, M.D., Miami

At Large

Three Year Term
John T. Stage, M.D., Jacksonville
Henry L. Harrell, M.D., Ocala
James T. Cook, M.D., Marianna
Charles L. Park Jr., M.D., Sanford
George S. Palmer, M.D., Tallahassee
Warren W. Quillian, M.D., Miami

The three lay members nominated by the Nominating Committee were approved by the Board as follows:

District "D"

Three Year Term
Mitchell Wolfson, Miami

At Large

Three Year Term
Dean C. Houk, St. Petersburg
Arthur Saarinen, Fort Lauderdale

RECOMMENDATIONS

1. BY-LAWS. — After careful consideration, the Board of Governors recommends to the House of Delegates the following amendments to the current By-Laws of the Florida Medical Association, Inc.:

a. Amend Chapter IV, Section 6, paragraph 2 to read as follows:

"The President, President-Elect, Vice President, Secretary, Treasurer, Immediate Past President, Speaker of the House of Delegates, Vice Speaker, PAST PRESIDENTS, Members of the Council on Specialty Medicine, and delegates to the House of Delegates of the American Medical Association shall be members of the House of Delegates with full rights and privileges."

This provides Past Presidents full privileges of the House of Delegates and removes the words "ex officio."

b. Amend Chapter VIII, Section 2, paragraph 1 to read as follows:

"Unless otherwise provided in these By-Laws, each Council shall be composed of the several Chairmen of the respective Committees in that Council. The term of service on the Council shall coincide with the term as Chairman of the Committee. The President shall appoint annually a Chairman of each Council."

c. Amend Chapter IX, Section 1, paragraph 5, by deleting the word "Commercial" preceding the words "Health Insurance," and Section 3, Subsection 2, by deleting the word "Commercial" preceding the words, "Health Insurance."

(Explanation: This changes the name of the Committee on Commercial Health Insurance to the Committee on Health Insurance as recommended by the Committee.)

d. Amend Chapter IX, Section 1, paragraph 2, to read as follows:

"THE COUNCIL ON ALLIED PROFESSIONS AND VOCATIONS: Committees on Dentistry, Law, Medical Assistants, Medical Technologists, Nursing, Pharmacy, Physical Therapy, Religion, Veterinary Medicine, and X-Ray Technicians."

(Explanation: This amendment adds a Committee on Religion to the Council on Allied Professions and Vocations. The establishment of this Committee was recommended by an ad hoc Committee on Medicine and Religion of the Board of Governors.)

e. Amend Chapter IX, Section 2, Subsection 7, to read as follows:

"7. National Legislation. — This committee shall be composed of a Key Contact Physician from each Congressional District in the State, one for each United States Senator from Florida and a chairman. The members shall be selected annually by the Board of Governors. The Chairman shall be appointed by the President.

"Subcommittee on Liaison with Federal Agencies. — This subcommittee shall be composed of one physician for each federal agency engaged in providing health services. The members shall be selected annually by the President, who shall also designate one member of the subcommittee as Chairman."

(Explanation: This amendment deletes reference to the AMA Key Contact Physician for the state. This system has been discontinued by the AMA. Change was recommended by the FMA Council on Legislation and Public Agencies.)

f. Amend Chapter IX, Section 3, Subsection 13, to read as follows:

"13. THE COMMITTEE ON POSTGRADUATE EDUCATION shall organize and conduct all postgraduate courses, seminars, and similar educational programs as sponsored by the Florida Medical Association and approve or disapprove all other similar courses where such action is requested of the Florida Medical Association. Where such a course involves any financial responsibility on the part of the State Association, the action of the Committee must also be approved by the Board of Governors. This Committee shall also act as a coordinating agency for all postgraduate educational programs and shall maintain close liaison and cooperation with all recognized medical schools in the state of Florida."

(Explanation: This amends the duties of this Committee, which was recommended by the Committee.)

g. Amend Section 2, Subsection 2, by adding the following sentence at the end:

"Interns, residents and fellows will pay a $10 fee at such time as they are eligible for reclassification of membership."

2. ANNUAL MEETINGS. — After careful consideration, the Board of Governors recommends that the following dates and sites be approved for the Annual Meetings of the Florida Medical Association, subject to satisfactory arrangements with the hotels:

1966	**Hollywood**	**May 11-15**	**Diplomat Hotel**
1967	**Bal Harbour**	**May 10-14**	**Americana Hotel**
1968	**Hollywood**	**May 8-12**	**Diplomat Hotel**
1969	**Bal Harbour**	**May 7-11**	**Americana Hotel**
1970	**Hollywood**	**May 6-10**	**Diplomat Hotel**

The 1965 Annual Meeting is scheduled April 21-25, Americana Hotel, Bal Harbour.

SUBCOMMITTEES OF THE BOARD

The Board reviewed and summarized the reports of subcommittees:

VENOMOUS SNAKE BITE. — This committee was responsible for a summation of the epidemiology of venomous snake bite during 1962. The results were published in the June 1963 issue of The Journal of the Florida Medical Association, to which a whole issue was devoted. These findings have received international recognition.

QUACKERY. — The Committee on Quackery is gathering information on the subject from our state and each physician is urged to forward material to the FMA headquarters when it is encountered. Since it is felt that this committee should be maintained, it is urged that members continue compiling evidence of quackery, seeking the cooperation of the State Board of Health in this area and encouraging continued public education.

FLORIDA MEDICAL FOUNDATION. — The Florida Medical Foundation, a nonprofit organization having for its purposes "to promote better medical care in Florida" was established by the Florida Medical Association's House of Delegates in May, 1956. The Charter was approved in September, 1956 and the By-Laws adopted in January, 1957.

In order to obtain tax exemption status, it was necessary to amend the Charter with reference to the objectives of the Foundation and this was done and approved by the Judge of the Circuit Court of Duval County in December 1958. The official ruling from the Internal Revenue Service stating that the Foundation was exempt from federal income tax and that contributions were deductible was received in January, 1959.

The revised objectives of the Foundation are as follows:

1. Improvement of the health and of the medical care of the people of Florida.
2. Sponsorship of graduate and postgraduate medical education without preference for any person.

3. Aid to persons of Florida needing financial charitable assistance who are pursuing an education in medicine.
4. Aid of deserving indigent or destitute physicians who by reason of illness or mental or physical incapacity need charitable assistance.
5. Promotion and sponsorship of medical research exclusively for public purposes and benefits.

A Trust Agreement with the Florida National Bank of Jacksonville was executed in February, 1958, which has several divisions. Trust Funds have been set up for the Dade County Medical Association (1957), the Florida Academy of General Practice (1959), and the Medical Center Clinic of Pensacola (1961) to administer medical student loans; agreements are in effect with the Florida United Community Funds, Inc., for a medical research program (1959); with the Florida State Board of Health for research and development programs (1959), and the Tampa General Hospital Medical Staff for education and research (1961).

In May, 1959, the FMA House of Delegates authorized voluntary contributions from the membership in the amount of $7.50 annually, to be used for medical education. Each year since, a solicitation has been sent to each member and there has been good response. Current assets of the Foundation, including Trust accounts and outstanding loans, exceed seventy thousand dollars.

The Board of Governors of the Florida Medical Association constitute the Foundation's Board of Directors. The current officers are Dr. Leo M. Wachtel, President; Dr. S. Carnes Harvard, Vice President; and Dr. Henry J. Babers Jr., Secretary-Treasurer. Mr. W. Harold Parham, Executive Director of the Florida Medical Association, serves as Executive Secretary of the Foundation.

Speaker: "The report carried and at this time, if you will look on pages 36 and 37, you will see that you just passed the first recommendation, which is a change in the By-Laws, which essentially provides Past Presidents of this organization full privileges of the House of Delegates and removes the words 'ex officio.' At this time, it is my pleasure to invite all Past Presidents of this organization to come forward and take their seats with the Delegates, where they should have been sitting for these many years."

The House applauded as Drs. Shaler Richardson, Eugene G. Peek Sr., Frederick K. Herpel and William C. Roberts took their seats in the House.

Dr. Palmer: "The Committee recommends that the Report of the Judicial Council be amended as follows: That the last sentence on page 40 of the Handbook read: 'It was felt that the sign on the building was legal without the use of the caduceus.' This deletes the phrase, 'and that it was ethical to charge interest on past due accounts.' Except for this amendment, the remainder of the Judicial Council report, its committee reports and the supplemental report, are approved as printed.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections; motion carried.

Judicial Council

JERE W. ANNIS, *Chairman*

Council:

The Judicial Council met on January 19, 1964, in the FMA Headquarters Building in Jacksonville, to hear a member of the society and counsel appeal censure of him by a component county medical association. After careful review of the evidence, it was determined that the action taken was in accordance with the Charter and By-Laws of the Association.

The review of a grievance against a member physician already acted upon by the local county medical society and appealed to this body was considered and the opinion of the local society exonerating the physician was upheld.

County medical societies were advised that the Florida Medical Association files were being closed on those grievances prior to 1963 on which the Association has had no recent reports. Ten grievances were referred to the county medical societies during 1963 on which no report of disposition has been received. Each county society was asked to submit an up-to-date report on these grievances.

The question of transfer of membership from one county society to another was referred to the Board of Governors, with a recommendation for investigation of the first county society with regard to the necessity for its existence.

The Council considered the AMA's stand on the ethics of profit-sharing plans and unanimously voted that it is not unethical to establish or participate in a profit-sharing plan or professional service corporation, per se.

It was unanimously agreed that, upon reclassification to dues-paying status, intern and resident members of the Florida Medical Association who have not previously done so shall be required to pay the regular entrance fee.

A letter from the St. Lucie-Okeechobee-Martin County Medical Society stating that the physicians of Martin County had voted in favor of remaining in the three county medical society was received as information, accepted by the Judicial Council, and is included in this annual report for the information of the House of Delegates.

Interim opinions with regard to the "Optometric Building" and with regard to the ethics of charging interest on past-due accounts were reviewed by and concurred in by the Council. It was felt that the sign on the building was legal without the use of the caduceus.

The policy of the House of Delegates referred to the Judicial Council for implementation regarding the corporate practice of medicine has been considered and the appropriate specialty groups consulted. Progress to date indicates there is unanimous agreement that no physician should enter into a contract whereby professional services are purveyed by a hospital. The Council will consider this subject again following the annual meeting.

Committees:

Archives. — The Committee on Archives has continued its efforts in communicating with the physicians who are members of the Florida Medical Association and are in the 40-50 year age group. These communications have been sent to complete our Archives on the entire membership of our Association. Their response has been fairly good in that we now have completed 372 records of members in this age group.

We have attempted to follow up the remaining members in the over-60 age group, as well as the 50-60 age group. There still remain over 800 members in these two age groups who have not responded to our communications. Amazingly, some of these members have been very active in the Florida Medical Association.

This year, we have decided that we will not exhibit at the annual meeting, as we have for the past two years. If the older age groups respond as they should in sending in the Archives folders, then the Archives Commit-

tee will have data plentiful for a very fine exhibit at next year's annual meeting. The Archives Committee welcomes any historical records, photographs or pertinent information to the Florida Medical Association.

The Association has lost a number of its fine members during the past year and a list of these names is given below:

April 1962
R. Henry Baldwin—Palm Beach

January 1963
B. L. Arms—Leon-Wakulla-Jefferson

May 1963
R. Marshall Faver—Dade
Paul K. Jenkins—Dade

June 1963
Allen M. Ames—Escambia
Henry E. Branca—St. Lucie-Okeechobee-Martin
Sherman B. Forbes—Hillsborough
William H. Gardner—Palm Beach
Joseph Halton—Sarasota
Arthur T. Rask—Palm Beach
Philipp R. Rezek—Dade

August 1963
J. Rocher Chappell—Orange
A. Edward Citron—Dade
Julio J. Guerra—Pinellas
William F. Reavis Sr.—Lake

September 1963
Willie J. Vinson—Dade

October 1963
Robert E. Blount—Lake
Willard L. Fitzgerald—Dade
Webster Merritt—Duval
Leigh F. Robinson—Broward
Eugene D. Simmons—Duval

November 1963
L. Snydor Laffitte—Duval
Joseph R. West—Palm Beach

December 1963
J. Clifford Boyce—Seminole
Harry L. Brillhart—Duval
John M. Gorman—Duval
John B. O'Neill—Pinellas
John C. Patterson—Sarasota
Julian Robinson—Dade
George O. Wood—Pinellas

January 1964
Harold M. Beardall—Orange
Stanley M. Mitnick—Dade
Rupert H. Stovall—Broward

February 1964
J. Maxey Dell Sr.—Alachua

Supplemental Report

COMMITTEE ON ARCHIVES

CLIFFORD C. SNYDER, *Chairman*

Since the Handbook was compiled, the Association has lost the following members through death:

March 1963
Edward D. M. Angell—Broward

January 1964
Joshua C. Dickinson—Hillsborough
John D. Griffin—Polk
A. Raymond Haisfield—Escambia
W. Lawson Shackelford—Palm Beach

March 1964
John N. Moore—Marion
John D. Reeves Jr.—Alachua
Clarence A. Rudisill—Hillsborough
Clifton A. Young—Pinellas

April 1964
John F. Chapman—Palm Beach
Russell H. Dean—Duval
Edwin C. Hanson—Marion
S. Carnes Harvard—Pasco-Hernando-Citrus
Harold T. Lawler—Sarasota
Clarence D. Rollins—Duval

Grievance Committee. — The Grievance Committee did not meet, but has empowered the Judicial Council to act for it in referring grievances to the local society and in dropping from the records those grievances more than two years old, which were inactive at the present time.

Medical Licensure. — During 1963 the Board of Medical Examiners examined for licensure 454 applicants; 441 received licenses.

Of the number whose applications had been rejected by the Director, five requested that their application be reviewed by the entire Board. This request was granted and all five applications were rejected.

During the year four licenses were revoked for illegal and fraudulent practices (two of these cases are still under appeal); two licenses have been suspended; six hearings were held on charges of unprofessional or immoral conduct; two hearings on narcotic charges, and there were 14 semiannual appearances of doctors who are on probation.

Current figures for the 1964 registration are:

1964 Registration paid—8,596 (Florida 5,612; out of state 2,984)
In active military service—391
Suspended for nonpayment of registration—645 (out of state)
Retired—172
Unlicensed physicians registered as interns, residents and house physicians in Florida hospitals—589

The Board has considered among other matters the following: (1) It reaffirmed unanimously opposition to reciprocity or endorsement with other state or national licensing boards; (2) considered measures to bring about Florida licensure for all physicians within state borders; (3) discussed the possibility and advisability of encouraging reciprocity with other Basic Science Boards. Some members of the State Board feel that Florida is being deprived of excellent mature physicians, particularly medical teachers, who for varying reasons may find difficulty in passing Basic Science examination. There are many ramifications of Basic Science provisions including licensure of allied professions, osteopaths and chiropractors; nevertheless the Board will welcome recommendations and advice in respect to this phase of its activities. (4) The Board would like to re-emphasize the danger of Three D's— (a) domestic difficulties, (b) drudgery, and (c) Demerol. Nearly all physicians addicted have these three problems. (5) The Board attempts to rehabilitate alcoholics and addicts by utilization of physician friends of the afflicted doctor in the community where he practices. Rehabilitation, not punishment, is emphasized. (6) The Board has increased its prelicensing investigation of physicians whose credentials are at all suspect.

The 1964 meetings of the Board will be held at the Deauville Hotel, Miami Beach, on June 26-30, 1964; and at the Robert Meyer Hotel, Orlando, on November 20-24, 1964.

Membership and Discipline. — No problems have been presented to the Committee on Membership and Discipline this year.

Recommendations:

1. It was unanimously resolved to recommend to the House of Delegates that a change be made in the Rules and Procedures of the Judicial Council which were adopted on May 28, 1961, this change to be as follows:

> **"3. . . . If the component county medical society does not act within one hundred eighty (180) days, the Grievance Committee may assume original jurisdiction, investigate and make recommendations to the Judicial Council."**

(As currently written, the procedures allow for sixty (60) days limit.)

2. The Judicial Council considered the request of the Walton-Okaloosa-Santa Rosa County Medical Society to form three separate county medical societies and unanimously recommends:

- **a. That a Charter be issued to the Walton County Medical Society.**
- **b. That a Charter be issued to the Okaloosa County Medical Society.**
- **c. That a Charter be issued to the Santa Rosa County Medical Society.**
- **d. That the issuance of these new charters be contingent upon these new county medical societies adopting constitution and by-laws or being incorporated with by-laws not in conflict with the Charter and By-Laws of the Florida Medical Association, Inc. The determination of compliance with this provision shall be made by the Judicial Council.**
- **e. That the Charter of the Walton-Okaloosa-Santa Rosa County Medical Society be revoked.**

"On Resolution 64-2, Amendment to By-Laws, by the Indian River County Medical Society, the Committee recommends that this resolution be referred to the Board of Governors for further study and recommendation to the House of Delegates.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections; motion carried.

Resolution 64-2

Amendment to By-Laws
Indian River County Medical Society

It is the desire of the smaller county medical societies that I have consulted to have full representation at the House of Delegates at both sessions of the House. It is impossible at times for some delegates to remain during the entire meeting and I would like to recommend a By-Laws change to allow county medical societies having two or less delegates to seat an alternate in the place of the seated delegate at any time the delegate is unable to represent his county medical society in the House.

AMENDMENT TO BY-LAWS

CHAPTER IV, SECTION 11, TENURE OF DELEGATES

A delegate who has been officially seated at a meeting of the House of Delegates shall remain a delegate of the component society which he represents throughout all sessions of that meeting, and his place shall not be taken by any other delegate or alternate, EXCEPT DELEGATES FROM COUNTY MEDICAL SOCIETIES AUTHORIZED ONE OR TWO DELEGATES MAY HAVE THEIR ALTERNATES SEATED IN THEIR PLACE AT ANY TIME THEY ARE UNABLE TO SERVE. Each delegate seated at an Annual Meeting shall serve until the next Annual Meeting, and shall serve at all interim or called meetings between Annual Meetings, unless the component society by certification of its president or secretary duly designates a different delegate.

"Resolution 64-6, Welcome and Invitation to AMA, by Burns A. Dobbins Jr., the Reference Committee recommends that this resolution be amended by adding the words 'at all times' at the end of paragraph 3, and deleting the last two paragraphs.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections; motion carried.

Resolution 64-6

Welcome and Invitation to AMA
Burns A. Dobbins Jr., M.D.

WHEREAS, The American Medical Association will hold its 1965 Clinical Convention in Miami Beach; be it

RESOLVED, That the following welcome and invitation be extended:

The Florida Medical Association is pleased that Florida has again been chosen as the state for a convention of the American Medical Association and welcomes its officers, delegates, members and guests to the Land of Sunshine at all times.

"The resolution 64-15, AMA Prepaid Life Membership, by the Brevard County Medical Society, the Committee recommends approval as submitted.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Resolution 64-15

AMA Prepaid Life Membership
Brevard County Medical Society

Whereas, It is the desire of essentially all members of the medical profession to remain members of the American Medical Association during their life; and

Whereas, Most such physicians and surgeons would probably prefer to arrange for such membership during their years of high productivity and before retirement; and

Whereas, The continuing identification of such members with organized medicine is highly desirable; and

Whereas, The American Medical Association, while excusing active members from the payment of AMA dues for reasons of financial hardship, illness, retirement from active practice, or over 70 years of age, does not continue scientific publications except by personal subscription and does not offer opportunity for prepayment of life membership; therefore, be it

RESOLVED, That the House of Delegates of the Florida Medical Association go on record as favoring such a prepaid life membership proportionately similar to that offered by the Southern Medical Association to its members, and that eligibility for such prepayment membership be limited to those members who have been members of the American Medical Association for twenty-five years or longer or that have attained the age of fifty-five (55) years; and be it further

RESOLVED, That the delegates to the American Medical Association from the Florida Medical Association be requested to propose such a resolution to the House of Delegates of the American Medical Association for consideration at the next annual convention.

"On resolution 64-17, Mandatory FMA Membership for Licensed Practicing Physicians, by the Palm Beach County Medical Society, the Committee recommends that this resolution be disapproved. The mechanism for accomplishing the purposes of this resolution is already available through the Board of Medical Examiners of Flor-

ida. The Committee urges that use be made of this body for necessary disciplinary control.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

"The Reference Committee recommends that Resolution 64-21, Invitation to the Florida Medical Association to Hold Its 92nd Annual Meeting in Jacksonville, Florida, by the Duval County Medical Society be approved with the following amendments: That the reference to a specific meeting (92nd) be deleted. That the final paragraph be amended to read: 'Resolved, That the Board of Governors seriously consider the invitation from Duval County and, if feasible, at the earliest date possible for the best interests of the Association, schedule an Annual Meeting in Jacksonville.'

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried.

Resolution 64-21

Invitation to Florida Medical Association to Hold Its Annual Meeting in Jacksonville, Florida Duval County Medical Society

Whereas, the Florida Medical Association has contracted through 1965 to hold its regular scientific meeting in Miami, Florida;

Whereas, no further immediate contracts are known to be in existence with the Florida Medical Association;

Whereas, it is recognized that Duval County is the third largest Medical Society in the State of Florida, and;

WHEREAS, the interests of the physicians in Duval County are high in their desire of bringing to the City of Jacksonville the Annual Meeting of the Florida Medical Association;

RESOLVED, That the Board of Governors seriously consider the invitation from Duval County and, if feasible, at the earliest date possible for the best interests of the Association, schedule an Annual Meeting in Jacksonville.

"The Reference Committee wishes to commend the Speaker of the House for his expert handling of the meeting and for the expeditious manner in which he conducted the first meeting of the House of Delegates. We sincerely hope he can continue the good work today.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

"Your Reference Committee wishes to commend our President, Dr. Warren W. Quillian, for his excellent and scholarly address, 'One Man's Philosophy,' which expressed a philosophy that every member of the Association would do well to emulate.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

"Mr. Speaker, I move the adoption of this report as a whole."

Motion carried.

Dr. Palmer thanked the members of his Reference Committee who helped formulate these recommendations: Drs. Edward Jelks, Gordon H. McSwain, James L. Anderson and L. Washington Dowlen.

REPORT OF REFERENCE COMMITTEE NO. IV

Legislation and Miscellaneous

Dr. James F. Cooney, Chairman: "Reference Committee No. IV gave careful consideration to items referred to it and makes the following report:

"The Reference Committee considered the Report of the Council on Legislation and Public Agencies and recommends that it be approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Council on Legislation and Public Agencies

H. PHILLIP HAMPTON, *Chairman*

Council:

The Council prepared a summary of tax-supported health care programs in Florida which was presented to the annual meeting of the county commissioners in October, 1963.

The Council prepared a statement concerning medical care for the aged which, after approval by the Board of Governors, was presented to the Ways and Means Committee of the United States House of Representatives in November, 1963.

At a meeting of the Committee on State Legislation and Subcommittees on Liaison with State Agencies held in conjunction with the Committee on Indigent Care of the Council on Medical Services, it was concluded that the major medical legislative need at the state level was a more adequate appropriation for the Hospital Service for the Indigent program in Florida.

Efforts have been made to improve relations between the physicians of Florida and the State Department of Public Welfare which is administering during this biennium $42,285,975 providing health care to categorized indigent in Florida.

Committees:

National Legislation. — During March of this year all Congressmen were visited in their Washington offices by officers of the Association and the key contact physicians. With one exception, all Congressmen expressed opposition to a program of medical care for the aged financed through use of the social security mechanism. Much interest was directed toward continued improvement in the present Medical Assistance for the Aged program and that this relatively new program be permitted adequate time for full implementation by all states.

Congressmen were again reminded to refer correspondence from constituents regarding lack of medical care because of inability to pay for it to the key contact physicians for follow-up and assistance for deserving cases.

Acknowledgment to the Congressmen was made for their exemplary Congressional representation for all Florida citizens.

The Council continues to maintain liaison with the AMA and its Washington office regarding legislation of national interest. Through the Council, the AMA program of "Operation Hometown" has been disseminated to all county medical societies for appropriate implementation.

State Legislation. — The major legislative goal of the FMA for the 1963 session of the Florida Legislature was passage of a Medical Assistance for the Aged (MAA) program, implementing further the Kerr-Mills Law. This was accomplished. During this session of the legislature our own Dr. Edward Annis, President of the AMA, gave an extremely effective talk to a joint session of the House and Senate.

The Committee on State Legislation and the Subcommittee on Liaison with State Agencies met on November 24, 1963. As a result of this meeting and action of the House of Delegates at the May 1963 Annual Meeting of the FMA, the following was adopted as the legislative program for the 1965 session of the Florida Legislature with the understanding that additional items may be added:

1. Active support for adequate appropriation of state funds sufficient to provide a comprehensive health care program for indigent citizens of all ages be continued.
2. Good Samaritan legislation to provide legal immunity for physicians who in good faith render emergency care at the scene of an accident.
3. Restoration of Section 394.21 Florida Statutes or similar legislation providing for nonjudicial involuntary hospitalization for the mentally ill.
4. Establish as firm policy the position of opposition in principle to legislation providing statutory privileges for physicians to the medical staffs of tax-supported hospitals or to any hospitals, for that matter.

The general consensus of this Committee as to our legislative program should be reiterated as follows:

1. It should not involve many and various items;
2. It should be limited to items which significantly affect the practice of medicine as a whole and are considered to be of major importance to the best interests of the public health and welfare; and
3. All specialty groups, county medical societies and other segments of organized medicine are requested to submit proposed items of legislation to this Committee, keeping in mind these two objectives.

There is need for closer cooperation and support from the county medical societies. There is no place for unilateral action either by county medical societies or individual physicians in a contrary position of either support or opposition to specific items. This is confusing and disturbing both to the legislators and to our representatives who work hard and long to line up support. Because of the recent legislative reapportionment we will lose old members of the legislature and have many new ones. It is important that individual members of the Association who know our lawmakers as personal friends or as patients keep them informed as to our objectives and the reasons for them. There is no better time than now and in the case of newly elected legislators, right after this year's elections.

Recommendations:

1. **That the Florida Medical Association request the Florida Legislature to make an annual appropriation of 50¢ per capita for the Hospital Service for the Indigent program as prescribed in Chapter 401 Florida Statutes.**
2. **That the Florida Medical Association request the State Board of Public Welfare to deduct immediately incurred or anticipated medical expenses from estimated income in considering financial eligibility of applicants for MAA.**
3. **That the Florida Medical Association request the State Board of Public Welfare to deputize county social welfare workers to make eligibility determinations for MAA.**
4. **Approve retention of the State Tuberculosis Board for management of our State Tuberculosis Hospitals.**
5. **Further development of the school education program on the dangers of smoking.**
6. **Provision in the state law for emergency involuntary hospital admission of suspected psychotic patients.**

"On the report of the Council on Medical Economics, we wish to consider each committee report individually.

"The Reference Committee considered the report of the Committee on Advisory to Blue Shield and recommends that it be approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

"The Reference Committee recommends that the last sentence of the last paragraph of the report of the Committee on Commercial Health Insurance be deleted.

"Mr. Speaker, I move the adoption of this portion of the report as amended."

No discussion; no objections, motion carried.

"The Reference Committee recommends that the Report of the Committee on Fee Schedules be approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

"The Reference Committee recommends approval of the report of the Medicare Mediation Committee as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

"The report of the Committee on Members Insurance is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

"The report of the Committee on Occupational Health is approved as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Council on Medical Economics

BURNS A. DOBBINS JR., *Chairman*

Council:

The reports of the Committees with recommendations have been presented to the members of the Council and are submitted with Council approval.

COMMITTEES:

Advisory to Blue Shield. — Two meetings were held since the last report, namely on September 29, 1963, and on March 1, 1964. In addition, members of the Committee have attended each of the meetings of the Blue Shield Board of Directors.

The program of publishing editorials by members of the Committee and/or other appropriate individuals as an educational program was reactivated in the manner previously established.

Recommendations:

1. **That the Committee lend its support to the recommendation of the Florida Medical Association with respect to establishment of utilization committees in hospitals throughout the state and that each member of the Committee of Seventeen actively encourage and assist in the establishment of these utilization committees in hospitals in their respective areas.**
2. **Because of rapidly rising hospital costs and increasing expenditures on the part of Blue Cross, better liaison and more accurate transfer of information regarding these expenditures should be achieved. Therefore, it is recommended that the chairman of the Committee of Seventeen and two members attend the Blue Cross Board meetings and conversely, that the Chairman of the Blue Cross Board and two members be invited to meet with the Committee on a regular basis.**
3. **It is recommended that the $7,500 family income level be accepted for Service Benefits provided that the fee schedule be based upon the 1962 Relative Value Studies of the Florida Medical Association with the present conversion factors now in use in the high option Federal Employees' program be maintained, and that any further change in the Service Benefits income levels be contingent upon a relative change in the conversion factors.**
4. **If the $7,500 income level is accepted by the Federal Employees Program, it is recommended that the same contract be made available to the general public at the same $7,500 service benefit level.**

Commercial Health Insurance. — The Committee on Commercial Health Insurance of the Florida Medical Association held its midwinter meeting on Saturday, December 21, 1963, at the Robert Meyer Motor Inn in Orlando.

The following summarizes the Committee's activities and recommendations:

The Board of Governors approved the Commitee's recommendation that the title of the Florida Medical Association's Committee on Commercial Health Insurance be changed to read: "Committee on Health Insurance."

The publication "Guide for the Establishment of a Health Insurance Review Committee" has been revised so as to provide that:

(a) The Chairman of the local Insurance Review Committee be urged to attend the Executive Committee meetings of his respective county medical society.

(b) That members of local Insurance Review Committees be encouraged to assist in establishing hospital staff utilization committees and coordinate activities of both committees where the need is indicated.

(c) Insurance Review Committees should recommend a usual and customary fee following arbitration and not just state "fee was excessive."

Recommendations:

1. **That the Florida Commission on the Cost of Medical Care be requested to continue its studies regarding increasing costs of medical care and sponsor informational and educational statewide conferences covering the subjects of both health insurance and Blue Cross and Blue Shield.**
2. **That educational conferences for chairmen of Insurance Review Committees of county medical societies and chairmen of Hospital Staff Utilization Committees be conducted through the joint efforts of the Florida Medical Association and the Florida Hospital Association.**
3. **That the review form of the Health Insurance Council be changed to include space for review by competent medical authority of the involved insurance company before referring the claim to the State Insurance Review Committee or a local Insurance Review Committee.**

The Committee is of the opinion that precedent had been set by the House of Delegates in requesting that local Hospital Staff Utilization Committees be set up in Florida hospitals; also, that the House of Delegates had requested that county Insurance Review Committees be established. It is further suggested that Speakers' Bureaus of our county medical societies adopt this subject as paramount at this time and train its speakers to address lay organizations as to what FMA is doing to halt the spiralling cost of medical care.

Fee Schedules. — This is a continuing report to supplement that given last year. Please refer to last year's report, especially that portion dealing with our proposals to the Florida Industrial Commission. Our proposals were finally accepted by the Commission and this new concept was officially put into effect on October 1, 1963. Because of this new approach the physicians, the insurance company personnel and the Commission personnel were confused. Many complaints have been received and steps have been taken by FMA and the Florida Industrial Commission to clarify the program and to explain it more fully.

This Committee's latest meeting was on March 1, 1964 and the Workmen's Compensation program was fully discussed. Medicare was briefly discussed and it was reported that a special FMA committee is working on this. The Veterans Administration fee schedule was discussed briefly. All other programs to be brought into line with the Florida Relative Value Studies must wait until these programs are working satisfactorily.

Recommendations:

1. **We recommend that our actions in developing and putting into effect the new Workmen's Compensation**

program be reaffirmed. We recommend that this program be strongly supported by every member of the Florida Medical Association in spite of the present difficulties until such difficulties can be corrected. We feel that this program should be given a fair trial.

2. **We endorse Dr. Thomas J. Bixler in his position as Chairman of the Medical Advisory Committee to the Florida Industrial Commission. We also endorse Dr. Bixler as the participant representing the Association in the proposed Florida Industrial Commission's regional, educational and informational conferences planned for the near future. We also recommend that FMA Committees give support and be available as needed in these meetings.**
3. **We recommend development, if possible, of a Section in the Workmen's Compensation manuals covering "Evaluations" peculiar to Workmen's Compensation programs.**

Medicare Mediation. — This report is made on a calendar year basis to coincide with the accounting procedures of the fiscal administrator, Blue Shield.

During the year, six meetings were held — four in Jacksonville, one in Hollywood and one in Gainesville. Attendance at all meetings was excellent.

Appreciation is expressed to the county committees for their cooperation and assistance. Their ability to conduct "on the spot" investigations is of inestimable value in making equitable recommendations for settlement of claims.

Blue Shield paid 13,519 claims to physicians for a total of $1,158,349, an increase of $132,824 over the amount paid in 1962. Of these claims, 826 (6.1 per cent) were referred to the county and state committees for consideration, an increase of almost 50 per cent. The number of physicians participating was 1,987, or 140 more than in 1962.

The Medicare contract with the Office for Dependents' Medical Care was renewed effective July 1, 1963, based on the 1962 Florida Relative Value Studies insofar as applicable to Medicare. The differences between RVS codes and Medicare codes have caused considerable confusion and have greatly increased the work of the Committees. President Quillian has, therefore, reactivated the Medicare Negotiating Committee to assist in correlating these differences.

Members Insurance. — The Committee on Members Insurance is delighted to report that there has been increasing participation by FMA members in the following insurance programs sponsored and approved by the Association:

Professional Liability
Disability Income Protection
Catastrophe Hospital-Nurse Expense
Accidental Death and Dismemberment
Office Overhead Expense

In addition to the above programs, Marsh & McLennan, Inc., who serves as insurance administrator for the Association, makes available the following coverage:

Senior Disability Income
Personal Catastrophe One Million Dollar Excess Policy
Owners', Landlords', and Tenants' Office Premises Liability
Employers' Surplus Lines Excess Professional Liability

To promote wide-spread participation, changes have been made in program administration to permit Association members to obtain coverage through their local insurance agents. Another important improvement is the broadening of coverage under the Disability Income plan from $150.00 weekly benefit to a maximum of $225.00.

A loss ratio of 147.5 per cent occurred in the Catastrophe Hospital - Nurse Expense plan. In all other programs, the earned premiums covered the claims paid by a liberal margin. The final figures for 1963 on Professional Liability claims are not available as of this writing. However, the experience for the first six months suggested that there would be a low loss ratio in this area also.

Occupational Health. — No particular problems of Industrial Medicine or Occupational Health have been encountered during the year. The chairman recommends that employment of the handicapped be given consideration by the Committee in the future, with emphasis placed on the possibility of legislative action permitting a handicapped individual to sign a waiver regarding his disability in order to protect the insurance carrier and the employer against aggravation of said handicap while on the job. This may assure an opportunity for employment for larger numbers of handicapped persons.

"The Reference Committee considered the Report of the Council on Special Activities and recommends approval as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Council on Special Activities

WALTER C. PAYNE SR., *Chairman*

Council:

The Advisory Committee to the Woman's Auxiliary to the Florida Medical Association has been very active this year. The highlight to date was a well attended and very successful Fall Conference and Board Meeting at Guy Lombardo's Port O Call, at Tierra Verde, near St. Petersburg, Florida, October 15-16, 1963. The Committee was asked to review a good deal of mental health material just prior to this meeting. The Mental Health Committee was commended for its industry, and we recommended that the approval of the respective county societies be obtained where literature was to be distributed or new mental health programs were to be put on. The conference was addressed by Dr. Warren W. Quillian, President of the Florida Medical Association, and by Dr. H. Phillip Hampton, who presented a Legislative Roundup. Problems have arisen, which were handled with dispatch as a result of the sound judgment of the Auxiliary officers.

No problems nor activities have been presented to the Board of Past Presidents this year. Speaking for the Board of Past Presidents, I feel that I express the feelings of each member of the Board when I state that we are happy and pleased that the Association is asking our Board to assume certain specific duties. For the honor the Association has shown us, we shall be grateful always. It will be a source of comfort and satisfaction to know that the Association feels we can still be of service.

All five delegates from the Florida Medical Association to the American Medical Association attended both the annual meeting and clinical meeting in Atlantic City, New Jersey, and Portland, Oregon. It has been the custom of your delegates to caucus at regular intervals during the meetings at which time all Florida Medical Association members in attendance are asked to be present in all deliberations. The delegation has worked smoothly and harmoniously. Regardless of personal feelings each delegate has always voted and expressed his opinion in the best interests of the Florida Medical Association as he saw it. The delegation has always followed the mandates of the House of Delegates of our Association. Your delegation welcomes your suggestions and criticisms.

Recommendation:

The Woman's Auxiliary has grown greatly in the past 25 years, and the Association appreciates its good work and great influence. Because of this fact, the Advisory Committee is urged to continue, as in the past, to encourage a close liaison between the component county medical societies and their auxiliaries.

"Resolution 64-3, Confusion in Workmen's Compensation Fees, was withdrawn by request of

the Delegate from the Indian River County Medical Society, yielding to Resolution 64-13 which covered essentially the same material."

"Resolution 64-4, Consent for Autopsies, by the Pinellas County Medical Society was considered and the Committee recommends that this resolution be approved in principle and referred to the Board of Governors for action.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Resolution 64-4

Consent for Autopsies

Pinellas County Medical Society

Whereas, There is no present Florida Statute providing for general consent for autopsies, and

Whereas, The present common law is deterrent to the performance of some autopsies because of the possibility of civil and criminal action against the pathologist, and

Whereas, The performance of autopsies is essential to good medical practice and is in the public interest, therefore be it

RESOLVED, That the Pinellas County Medical Society, Inc., recommends that the Florida Medical Association request the Florida Legislature to enact a law patterned after the following:

"A LAW TO PROVIDE FOR CONSENT FOR AUTOPSIES"

"Whenever a person dies and an autopsy is not ordered and done at the direction of a coroner, medical examiner, or other legally constituted investigating official, a physician may conduct an autopsy on the remains upon written consent of whichever of the following persons assumes custody of the body for purposes of burial: father, mother, husband, wife, child, guardian, next of kin, or, in the absence of any of the foregoing, a friend or person charged by law with the responsibility for burial. If two or more persons assume custody of the body then the consent of any one of them shall be deemed sufficient.

"Anyone authorized to give consent who signs any autopsy authorization shall be conclusively presumed to have assumed custody of the body for purposes of this law, and no cause of action shall lie against a physician performing an autopsy with such written authorization.

"Any such written consent may be given by telegram, and any telegram purporting to have been sent by a person authorized to give such consent will be conclusively presumed to have been sent by such person.

"If no one can be found who can authorize an autopsy under this law, then after a reasonable time, any physician may conduct an autopsy on the remains without written consent, and no cause of action will lie against such physician from any concerned person after the autopsy. A reasonable time for purposes of this provision shall be not less than twelve hours or more than forty-eight hours."

"The Reference Committee considered Resolution 64-5 on Poisonous Substances, by the Columbia County Medical Society, and recommends that it be approved in principle and referred to the Board of Governors for study and action.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections; motion carried.

Resolution 64-5

Poisonous Substances

Columbia County Medical Society

RESOLVED, That the Florida Medical Association condemn the sale of poisonous substances, such as members of the parathion family of drugs, and all other insecticides or poisons which can kill or injure humans, pets, or livestock; except that such poisons or insecticides may be sold by pharmacists, licensed in the State of Florida, provided each sale of such poison or insecticides be recorded in a "poison book" in the same manner as the sale of other poisons are now required by the Florida Statute. Moreover, be it further

RESOLVED, That the president of the Florida Medical Association appoint a committee to urge the Legislature of the State of Florida to make the appropriate changes in the Florida Statutes dealing with poisons as soon as possible, and that appropriate warnings and caution labels be affixed to all such poisons and insecticides sold.

"The Reference Committee considered Resolution 64-8, Medical Care for the Aging, by the Orange County Medical Society and recommends approval as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Resolution 64-8

Medical Care for the Aging

Orange County Medical Society

Whereas, In large part for political purposes proponents of the King-Anderson Bill (H.R. 3920) have declared that the Kerr-Mills program and all voluntary efforts cannot adequately meet the problems of medical care for the aging, and

Whereas, The medical profession should not be so naive as to believe that in all probability some compromise must ultimately be made and should be prepared to assume aggressive leadership through their official representatives in this eventuality, and

Whereas, Health insurance coverage of all citizens over 65 is a desirable objective, and

Whereas, This coverage should be extended on a voluntary basis in a manner consistent with the dignity and independence of each individual, and

Whereas, In the statement of the American Medical Association before the Ways and Means Committee, it was declared, "We have also suggested certain amendments to the Internal Revenue Code, designed to assist all taxpayers involved in financing hospital and medical expenses of the aging," therefore, be it

RESOLVED, That the Orange County Medical Society supports this declaration, believes it to be the most acceptable and positive approach to any existing deficiency in the medical care of the aged and favors the enactment by the Congress of the United States of an Act amending the Internal Revenue Code to provide the following:

1. Tax incentives for those citizens who have reached 65 and are able to provide voluntary health insurance for themselves;
2. Tax incentives for relatives or former employers who are able to provide such insurance for them;
3. Direct government assistance for those citizens who have reached age 65, and are otherwise unable to obtain such protection, to enable them to pur-

chase health insurance of their own choice, such portion of the Act to be administered in cooperation with each of the several states, and

4. Requirement that such insurance be guaranteed renewable, subject to certain minimum standards, and include catastrophic coverage,

and be it further resolved, That this resolution be forwarded to the House of Delegates of the Florida Medical Association at their next annual meeting with the recommendations that it, or one of similar intent, be presented by the delegates of this Association to the House of Delegates of the American Medical Association at their annual meeting and that copies of this resolution be sent to every county society in the state of Florida and to every state medical association.

"Resolution 64-9, Blue Shield, by the Orange County Medical Society was considered and the Committee recommends approval as printed in the Handbook.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Resolution 64-9

Blue Shield

Orange County Medical Society

Whereas, The Orange County Medical Society believes that Blue Shield of Florida has the ability to provide the best type of prepaid medical care protection for the citizens of Florida, therefore be it

RESOLVED, That the Orange County Medical Society recommends to the Florida Medical Association that Blue Shield of Florida be maintained and strengthened in every way possible; and that individual doctors and county medical societies give this Plan their wholehearted cooperation and support, and it is further

RESOLVED, That the resolution be submitted to the House of Delegates of the Florida Medical Association meeting for approval in session at Hollywood, May 1964.

"Resolution 64-13, Workmen's Compensation, was considered and the Committee recommends that this resolution not be adopted. We felt again that the new fee schedule had only been in operation seven months and time will clarify most of the discussion that was brought out at the meeting.

"Mr. Speaker, I move that this resolution be disapproved."

No discussion; no objections, motion carried.

"Resolution 64-16, Corporate Status for Physicians, Duval County Medical Society, was considered and the Committee recommends that it be approved.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections; motion carried.

Resolution 64-16

Corporate Status for Physicians to Apply to U. S. Internal Revenue Code

Duval County Medical Society

Whereas, There are several bills before Congress (H.R. 9217, H.R. 10070, H.R. 9690, H.R. 9874, H.R. 10418, and S. 2403) which would amend the 7701 Section of the Internal Revenue Code of 1954 so as to allow the Corporate Tax Status under State Law to apply to the Internal Revenue Code, and

Whereas, Physicians under present rulings of the Bureau of Internal Revenue are being discriminated against in the matter of Corporate Tax Status, and

Whereas, Many physicians have already incorporated under Florida Law, be it

RESOLVED, That the Duval County Medical Society endorses the passage of the above legislation and urges vigorous support of this legislation by the Florida Medical Association requesting the Florida Medical Association to present a similar resolution to the American Medical Association's Annual Meeting urging the Congress to pass legislation allowing the State approved Corporate Status to apply to the Internal Revenue Code.

"The Reference Committee considered Resolution No. 64-19, Medical Scholarship Program, as found in the delegates' packets. The committee recommends that this resolution be approved in principle and that it be referred to the Board of Governors for further study and action.

"Mr. Speaker, I move the adoption of this portion of the report."

No discussion; no objections, motion carried.

Resolution 64-19

Proposal for a New Approach to Florida's Medical Scholarship Program

Melvin M. Simmons, M.D.

Florida's Medical Scholarship Program should be revised if it is to meet its stated objective: to make the study of medicine possible for capable Florida students with meager financial resources, in return for their services as practicing physicians in those areas of Florida where our people do not have adequate medical care.

The cost of medical education has become so great that a scholarship of one thousand dollars per year will not enable a student with only modest financial resources to pursue the study of medicine. Further, the study of medicine has become so demanding that a student cannot spare time from his studies for gainful employment.

These and other undesirable features of the Scholarship program, together with the advent of the Government educational loan funds have resulted in a progressively smaller number of applicants for scholarships each year. This year there were thirteen applicants for ten scholarships.

If one compares the three present sources of funds to the student: the State scholarship, the A.M.A. loan guarantee fund, and the Federal Student Loan Fund (H.R. 12), it is obvious that the student will prefer the Federal loan because of its many advantages to him.

If this situation of availability of funds continues for long, we will have a medical profession oriented toward the Federal Government. If we desire to maintain our orientation toward and strengthen our ties with our Sate Governments, we must offer sources of funds to the students which are equally attractive.

In strengthening Florida's program for the provision of funds for medical education, however, precautions must be taken to insure that the leadership of the medical

profession in the guidance of the program will be continued as the program grows. There is probably no way in which the medical profession can more effectively insure its moral right to guide the further development of the program through the years than by sharing with the State in its costs. With these thoughts in mind, it is suggested that consideration be given to the drafting of a bill which would accomplish the following:

1. Create in the State Treasury the "Medical Student Loan and Scholarship Fund."
2. Increase the annual registration fee paid to the State Board of Health from $1.00 to $10.00 and provide that this ten dollars be deposited in the "Medical Student Loan and Scholarship Fund."
3. Provide that the State appropriate for the "Medical Loan and Scholarship Fund" an amount equal to the sum paid in annual registration fees by the profession to the fund.
4. Provide that all loan payments be made from the "Medical Loan and Scholarship Fund," and provide further, that all moneys received in repayment of loans be returned to the "Medical Loan and Scholarship Fund."
5. Set the amount of loan per year at $2,000.00.
6. Permit the number of loans to grow as the trust fund grows.
7. Permit the recipient of the loans to repay the money with —— per cent interest beginning the third year after graduation, or serve a period of compensatory practice in an area of need of one month for each $200 of scholarship assistance received.
8. Permit a recipient who elects to accept his loan as scholarship assistance to serve his period of compensatory practice in Public Health or in private practice in an accepted area of need.
9. Allow some credit toward repayment for each year of required service in the Uniformed Services.

Such a revision of the Florida Medical Scholarship program would:

1. Attract to the medical profession more of Florida's intellectually gifted students.
2. Make the pursuit of medicine possible to competent students regardless of their financial resources.
3. Provide a more equitable method of repayment by compensatory practice which would result in more graduates serving this period of practice in an area of need.
4. Insure the profession's moral right to give guidance to the loan and scholarship program as it develops through the years.

"The Reference Committee considered Resolution 64-20 on Opposition to Nationalization of Medicine, as presented to the First House of Delegates by Dr. Ralph Jack and recommends that this resolution not be adopted.

"Mr. Speaker, I move that this resolution not be adopted."

The Speaker read the resolution.

Dr. Cooney: "Considerable discussion was heard regarding this resolution, the Delegates to the AMA were consulted, and it was the opinion of all present that this resolution was superfluous."

Dr. Jack: "Mr. Speaker, I would just like the members of the House to know that this resolution was adopted by the House of Delegates of the Texas Medical Association on April 24."

Dr. Walter Jones asked that Dr. Edward Annis express his opinion.

Dr. Annis: "Unless I heard incorrectly, the statement of the resolution is not in accordance with the facts. I believe it stated that we reaffirm opposition to 'bricks-and-mortar' aid, and we do not have this policy. The policy of the AMA's House of Delegates is to support 'bricks-and-mortar,' so the resolution would not be factually correct in its 'whereas' to justify the action. The action of the House has been this—to reconsider and reevaluate all such programs, because as Dr. Jack's resolution points out, there have been instances where they are using this as an entering wedge. There are many parts of this program that have to be discussed and I would be cautious to change our policy as of the moment. I do not think it would clarify our own views among ourselves and it would be misused by our enemies in the public press.

"One thing I would like to tell this House—you have a very talented Reference Committee. A continuing study is being made of this whole matter now for recommendations and to get the factual material to report back to the membership of the American Medical Association, and as a delegate from Dade, I would be in favor of accepting the recommendation of the Reference Committee."

Someone moved that the action of the Reference Committee be tabled and that this resolution not be published.

The Speaker informed this Delegate that a resolution which is not approved is not published; so the motion was not seconded.

Motion carried.

Dr. Cooney moved the adoption of the entire report.

No discussion; no objections, motion carried.

Dr. Cooney thanked the members of his Committee; Drs. Melvin M. Simmons, Thomas M. Irwin and Madison R. Pope.

Dr. Russell B. Carson, Chairman of the Board of National Blue Shield, congratulated the House of Delegates on its action in bringing Florida up to a standard of Blue Shield care equal to the top 15 or 16 states in the country and promised, in his capacity as Chairman of the Board, during his three year term to make every effort to bring Blue Shield into and make it a part of organized medicine just as closely as possible.

Nominations for President-Elect were called for by the Vice Speaker, Dr. Evans.

Dr. Henry L. Harrell, of Marion: "We would like to place the name of Eugene G. Peek Jr. in nomination for President of the Florida Medical Association from Marion County. The Marion County delegation has been instructed to do so by

the vote of every single member of the Marion County Medical Society, because we think he is a well qualified man and is the best qualified man for the job at present.

"He is a graduate of the Medical College of Virginia and received his internship and residency training in Richmond. He has a busy, successful practice in Ocala. He has kept this successful practice, and in a little town like Ocala, you have to be a good doctor to do this—and being a good doctor is the first requisite for President of the Florida Medical Association. He has been very helpful in national legislation and has served this Association faithfully as Vice Speaker and Speaker, is at present President of the Florida State Board of Health, is a member of the Board of Governors, and we believe that he is really qualified for the job."

Dr. Walter Jones, of Dade: "An occasion like this rarely is presented to an individual. I would like to second the nomination of Dr. Peek. I have known him during his lifetime in this Association and I had the privilege, 22 years ago, of seconding the nomination of his father for President of the Association. I take great pleasure, as a past president, in seconding the nomination of Dr. Peek."

Dr. Shaler Richardson, Past President: "As a past president and one who has had much contact with Gene Peek in working for this Association, I wish to commend to you the election of Gene Peek as President-Elect. He will be a dynamic leader and will exert every effort to carry on the work of this Association. He is thoroughly familiar with all aspects of the workings of the Association and I recommend that you give him your unqualified support."

Dr. William C. Roberts, Past President, also seconded the nomination of Dr. Peek.

Dr. James N. Patterson, of Hillsborough: "The Hillsborough County Medical Association wishes to place in nomination for President-Elect the name of one of its most illustrious members, one known to all of you for his many valuable contributions to the progress of the Florida Medical Association.

"He was born in Tampa on February 10, 1913. He received his premedical education and medical degree from Emory University, graduating in 1937. He interned at Cincinnati General Hospital, where I first became acquainted with him. He took his residency in Internal Medicine at the Mayo Clinic in Rochester from 1938 to 1941. He then served in the United States Army and was stationed in a general hospital in the European theatre of operations, with the rank of lieutenant colonel. After the war he moved to Tampa for the practice of internal medicine. He has been active in civic and medical affairs. He has been King of Gasparilla, Director of the Greater Tampa Chamber of Commerce, and Chairman of the Hospital Planning Committee, Tampa Municipal Hospital. In 1949 he married the beautiful Kay Barker and they have five fine children. He has been very active in medical affairs. For the past 16 years he has been a delegate from the Hillsborough County Medical Association. He was appointed to the Florida Medical Association's Legislative Committee in 1951 and has been its chairman for the past ten years. He has served as a member of the Board of Governors since 1958. He has appeared before Congress on many occasions in our behalf, and for many years was the American Medical Association's Key Contact Physician for Florida. He is now Vice President of the Florida Medical Association. It is with great pleasure and pride that the Hillsborough County Medical Association places in nomination the name of our candidate, Dr. H. Phillip Hampton."

Dr. Hampton's nomination was seconded on behalf of the Pinellas County Medical Association.

Motion was carried that nominations be closed. Drs. Robert F. Dickey, of Dade, Rothwell C. Polk, of Duval, and Charles R. Sias, of Orange, were appointed as tellers.

The Vice Speaker announced that Florida's most illustrious medical son, Dr. Edward R. Annis, had consented to speak while the ballots were being counted.

Dr. Annis used this opportunity to explain a point of view that has not made the headlines and gave an excellent extemporaneous presentation covering AMA-ERF Student Loan Fund, the Government's Loan Fund, Federal Trade Commission's suggested rules and regulations regarding tobacco, activities of the AMA Headquarters and the Board of Trustees.

The House gave Dr. Annis a standing ovation.

The Vice Speaker announced that Dr. H. Phillip Hampton was elected President-Elect.

Dr. Cole and Dr. Patterson escorted Dr. Hampton to the rostrum.

The Vice Speaker called for nominations for Vice President.

Dr. Leo M. Wachtel, of Duval: "I have the privilege and the honor of nominating for Vice President of the Florida Medical Association that great son of Marion County, Eugene G. Peek Jr."



Following his election as President-Elect, Dr. H. Phillip Hampton of Tampa is escorted to the platform by Dr. James N. Patterson of Tampa (left) and Dr. Edward L. Cole Jr. of St. Petersburg (right).

Dr. Peek's nomination was seconded by Dr. Ralph Jack, of Dade.

Dr. Robert Zellner, of Orange, moved that nominations be closed and the Secretary be instructed to cast a unanimous ballot for Dr. Eugene G. Peek Jr.

Motion was seconded and carried.

Dr. Eugene G. Peek Sr. was asked to escort the new Vice President to the rostrum.

Dr. Peek Jr.: "On behalf of Dr. Hampton and myself, we want to thank all of those who worked for both of us. I think it is an honor to this society that two friends can run against each other and remain friends."

The Speaker called for nominations for Speaker of the House.

Dr. W. Dean Steward, of Orange, nominated Dr. James T. Cook, of Jackson-Calhoun, as Speaker of the House.

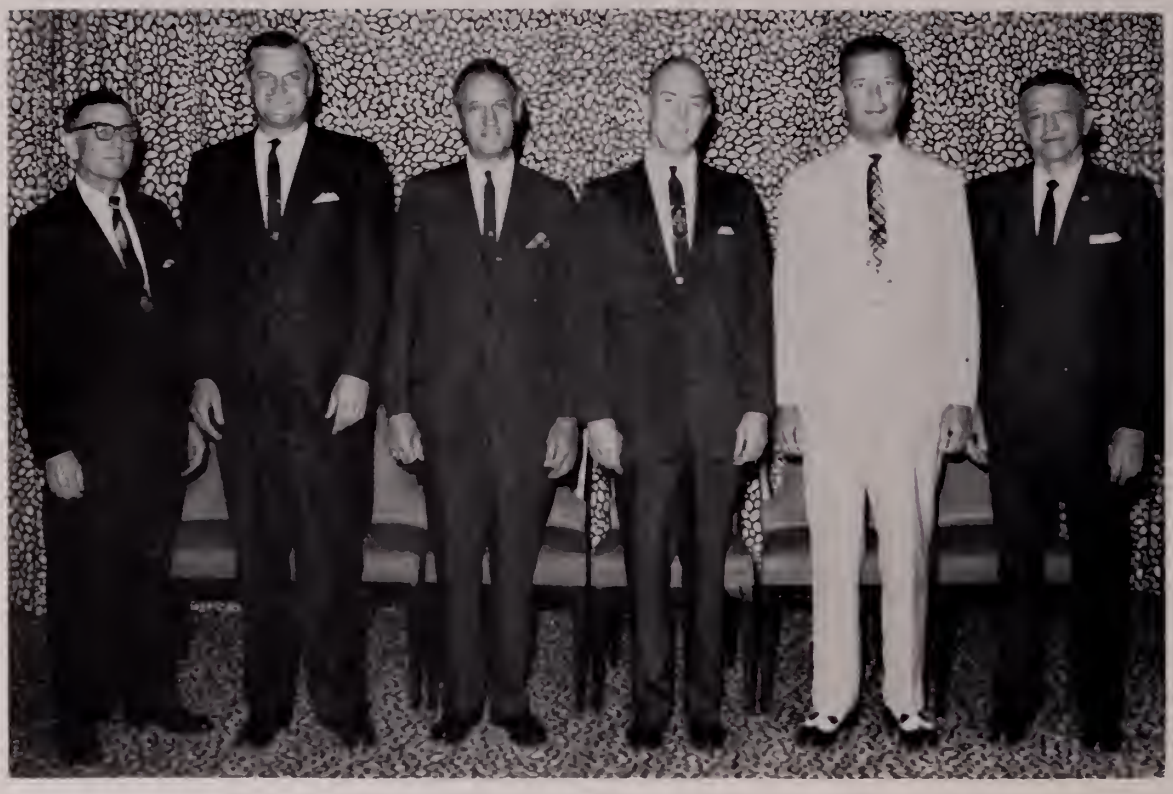
Dr. Walter E. Murphree, of Alachua, nominated Dr. Franklin J. Evans for Speaker of the House. This nomination was seconded by Dr. Edwin P. Preston, of Dade.

Motion was carried that nominations be closed and the same tellers were asked to serve again.

The Speaker asked Mrs. Hampton to stand and be recognized.

The President-Elect, Dr. Hampton, spoke briefly, thanking the delegates for the honor bestowed upon him.

Dr. Quillian: "I would like to say a few words not only to the House of Delegates, but to the entire membership of the Florida Medical Association. One of the privileges that one has in serving as President of this organization is having the opportunity to work intimately with a great many people. I am firmly convinced that the enthusiasm of the individual, the activity of the component county medical society as it is working out now is accomplishing a great deal to gain the respect of other organizations throughout the nation, those that comprise the American Medical Association. It is very heartening when one attends a meeting of the American Medical Association to see the favor and respect with which those representatives of Florida are received, and this is on account of individual members. We have observed the dedicated work of committee members, of councilmen, of Councils on various activities throughout the organization. I have enjoyed the privilege, particularly this last year, of working with a very dedicated Board of Governors, and there is a great deal of work that



Officers of the Association are (from left) Dr. Floyd K. Hurt of Jacksonville, Secretary-Treasurer; Dr. Eugene G. Peek Jr. of Ocala, Vice President; Dr. Franklin J. Evans of Coral Gables, Speaker of the House; Dr. Samuel M. Day of Jacksonville, President; Dr. H. Phillip Hampton of Tampa, President-Elect, and Dr. Warren W. Quillian of Coral Gables, Immediate Past President.

is accomplished by them as administered by the very efficient executive staff.

"Our thanks can be offered at this time to all of you who made this possible. I am glad to have a chance to say this, because, according to our schedule here, when this Past President's button is pinned on, that is the end, or as Jere Annis said last night, this means 'selah,' and I have always heard that that in the concordance is translated to mean 'shut up' because now you are a Past President. I promise to do that. I would like to express again my appreciation for the privilege and the honor of having been President during this year. It has been a happy year on account of the loyalty and help of so many. I would like to express my special thanks to my wife—in case she is able to rise and be recognized —to my understanding associate, the medical assistants in the office, and finally to my sympathetic banker, who prefers to remain anonymous."

The tellers reported and the Speaker announced that Dr. Franklin J. Evans had been elected Speaker of the House.

Dr. Simmons of Sarasota nominated Dr. James T. Cook as Vice Speaker.

Motion was carried that nominations be closed and the Secretary be instructed to cast a unanimous ballot for Dr. Cook.

The Speaker called attention to the Board of Governors' nominations for the Committee on Membership and Discipline as shown on page 36 of the Handbook and asked for additional nominations from the floor.

As there were no additional nominations, motion was carried that nominations be closed and the Secretary cast a unanimous ballot for the following:

District 3	Edward J. Lauth Jr., M.D., Miami	1968
District 4	Jack Q. Cleveland, M.D., Miami	1965
District 4	Nelson Zivitz, M.D., Miami Beach	1968
District 5	W. Wardlaw Jones, M.D., Dade City	1968
District 8	Thomas H. Bates, M.D., Lake City	1968
District 10	Ernest R. Bourkard, M.D., Tampa	1968
District 12	N. Worth Gable, M.D., St. Petersburg	1968

The Speaker asked for nominations for Delegates to the American Medical Association, three delegates and three alternates for two year terms

beginning January 1, 1965 and expiring December 31, 1966.

Dr. Edward W. Cullipher, of Dade: "In spite of my lack of experience at this sort of thing, I have been requested by the DCMA to nominate Dr. Reuben B. Chrisman Jr."

Nomination was seconded by Dr. Charles J. Collins, of Orange.

Motion was carried that nominations be closed and the Secretary be instructed to cast a unanimous ballot for Dr. Chrisman.

Dr. Henry L. Harrell, of Alachua, nominated Dr. Robert E. Zellner of Orange, as alternate Delegate for Dr. Chrisman.

As there were no other nominations, motion was carried that the Secretary be instructed to cast a unanimous ballot for Dr. Zellner.

Dr. George Palmer, of Leon, nominated Dr. Francis T. Holland, of Leon, as Delegate to the American Medical Association.

As there were no other nominations, motion was carried that the Secretary be instructed to cast a unanimous ballot for Dr. Holland.

Dr. William W. Trice Jr., of Hillsborough, nominated Dr. Madison R. Pope as alternate Delegate for Dr. Holland.

No other nominations were made and motion was carried that the Secretary be instructed to cast a unanimous ballot for Dr. Pope.

Dr. Charles Larsen Jr., of Polk, nominated Dr. Jere W. Annis as Delegate to the American Medical Association.

Dr. Robert F. Dickey, of Dade, seconded the nomination of Dr. Annis.

As there were no other nominations, motion was carried that the Secretary be instructed to cast a unanimous ballot for Dr. Annis.

Dr. G. Dekle Taylor, of Duval, nominated Dr. Leo M. Wachtel as alternate Delegate for Dr. Annis.

No other nominations were made and motion was carried that the Secretary be instructed to cast a unanimous ballot for Dr. Wachtel.

The Speaker called for nominations for the office of Secretary-Treasurer.

Dr. Jelks: "You will recall that the Duval Delegation assigned to me the privilege last year of nominating for the office of Secretary-Treasurer a man that we did not know a whole lot about. After a year's trial, we would like to present him again to you altogether on the record he has made this year. We would like to renominate Dr. Floyd K. Hurt for the office of Secretary-Treasurer."



Dr. Samuel M. Day of Jacksonville addresses the House of Delegates following ceremonies during which he was installed as President of the Association.

Motion was carried that nominations be closed and a unanimous ballot be cast for Dr. Hurt.

The Speaker asked Dr. Jere W. Annis and Dr. G. Dekle Taylor to escort the incoming President, Dr. Samuel M. Day, to the rostrum.

Dr. Quillian: "It is my pleasure, Sam, to offer you this gavel which is emblematic of the authority vested in you as you assume the presidency of this organization. Your qualifications are very high and your many years of service to the organization justify the reward and recognition which go with it. We congratulate you and we congratulate ourselves in having someone in whom we can place confidence, in that we have obtained a leader who will have the full cooperation of the membership."

Dr. Day: "President Warren and Members of the House: As one who grew up in this organization, I am grateful for being in this position. Today I am reminded of the saying that historians explain the past, economists predict the future, only the present is confusing. In the coming year, we are going to try to emphasize our scientific activities. You, by your actions at this meeting, have designated the Committee on Postgraduate Education to take a more active part. I would like to preach my text that I have been giving in several places, because I think it is so important at the present time, that of Workmen's Compensation, to be patient and urge the members of your

county society to be patient at this time. As was related in the Reference Committee, they are trying to collect statistics of the average fees of doctors; they are putting those fees in the IBM machines; it is true they are not paying them, and it is creating a lot of confusion, and it is creating some bookkeeping difficulties, but it is possible that we may be able to collect some statistics which will be valuable to us in the future and possibly can get us off the fee schedule, which is the aim of many of our members. So, be patient, please.

"Coming up we have another fight on Medicare; so I do not need to remind you that we should stay active in that field and as individuals we need to take an active part in the political campaigns that are ahead of us. I would like to urge, however, that you act through your organization, the Florida Medical Association, before you go to the public on actions that affect medicine, because it presents an ununited front when we go off in various directions and do not work through our Association.

"I would like to recognize my wife, who has been most patient with me through years of Florida medicine. I would like to say that somehow everybody seems to think a lot more of me when they know my Dolly."

Mrs. Day stood and was applauded by the assembly.

Dr. Day: "President Warren, we are grateful to you for the wonderful job you have done as our president. You have conducted your meetings with dispatch and with humor. I don't think we have ever enjoyed Board meetings more than those this past year interspersed with your tidbits of good humor. We appreciate the fine work you have done for us in Florida medicine and hope that this does not mean the end. I present this Past President's button, also, this Past President's Certificate, saying: 'With Honor, Warren W. Quillian, M.D., served the Florida Medical Association with distinction during his year as President. On behalf of the officers and members of our Association, this Certificate of Honor is affectionately bestowed.' "

Because Mrs. Quillian had sprained her ankle, Dr. Jack Cleveland and Dr. Charles Collins were asked by Dr. Day to present Dr. Quillian's picture to Mrs. Quillian at her seat in the audience.

Dr. Day announced that there would be a meeting of the new Board of Governors immediately following adjournment of the House of Delegates.

The Speaker asked Dr. G. Dekle Taylor to give the benediction.

Dr. Taylor: "Let us pray. Almighty God, designer of this great universe, we hope that our deliberations and actions at this meeting have been pleasing to Thee. Let us not forget the love of the Good Samaritan for his fellowman and the admonishment of the Great Physician, that we go and do likewise. Help us to remember, 'that love suffereth long, and is kind; love envieth not; love vaunteth not itself, is not puffed up.'

"Now may the love and peace of God which passeth all understanding and which the world can neither give nor take away, abide with you always. Amen."

The meeting was adjourned at 1:30 p.m.

Attendance at 90th Annual Meeting

Florida Medical Association

Registration for the Annual Meeting held at Hollywood May 7-10 reached a total of 2,143 for the four days, Thursday through Sunday. Of the total, there were 1,193 physicians, 472 members of the Woman's Auxiliary, 284 scientific and technical exhibitors, and 194 other guests.



The Presidency of the Florida Medical Association

Within a period of less than two months it has been my sad mission to attend the funeral of four past presidents of the Florida Medical Association. Dr. Carnes Harvard died April 5, age 62. Dr. Herbert White died May 11, age 66. Dr. David Murphey died May 16, age 58. Then last week on May 27, Dr. Shaler Richardson passed away at the age of 73. If I am not mistaken, Shaler Richardson had an active part in the affairs of the Association longer than any other member. It has been an honor to have enjoyed the friendship of these four men over the years, both within and outside of the Florida Medical Association.

Dr. Harvard and Dr. Richardson died literally "with their boots on." Dr. Harvard was in Jacksonville at a Board of Governors meeting when he fell incurring a fracture of one forearm and the pelvis. He was hospitalized and died four days later. Dr. Richardson was operating the afternoon before he died of a coronary the next morning. Dr. White and Dr. Murphey had been ill three and two years respectively.

This rapid depletion in the small group of past presidents has caused me to ponder over both the past and the future—especially as Shaler Richardson and I were the same age.

For years I have considered the group of past presidents as the "senior statesmen" of the Association. This because of age, because they have received the highest honor the Association can bestow, and because they have been able to watch the growth of the organization. At the last meeting of the House of Delegates an additional honor was given, namely, the past presidents were made members of the House of Delegates for life. Before this, the group had had the privilege of the floor.

Eighteen years ago I was honored by being elected the president-elect and assumed office in 1947. Since that time I have enjoyed the memories of my year in office, and the association within the group of past presidents. The annual past president's breakfast meeting is always the high light of the Association's meeting for this group. As the years go by, the bonds between the group of past presidents grow stronger.

What is the significance of the election to the presidency of the Florida Medical Association? I cannot speak for others, but to me it means as follows:

It gives the stamp of approval of the Association as to the elected physicians' ability, integrity and personality.

It means long hours of work on the affairs of the Association. Without the help of efficient managing directors, the Association work needs would be too much of a burden to compensate for the honor. In my day we had Stewart Thompson. Of late we have had Harold Parham. Stewart Thompson during his lifetime, and now Harold Parham, literally live with and for the Florida Medical Association.

During the years as president, and later as past president friendships are made, and personal bonds are built which will go through life.

The office gives the holder thereof the opportunity of watching the younger members mature and assume greater responsibilities in the affairs of their Association.

The office of president carries with it the approval of the Association. There are any number of the Association's membership capable and worthy of being elected to the presidency who may never receive this honor, men more deserving and more capable than any or most of our past presidents. But this is such an honorable position that the office should seek the man, not the man the office. The county or district may and should choose a candidate and foster him to the fullest. This is simple democracy.

I want again to thank the Association for the privilege of being a past president of the Florida Medical Association.

William C. Thomas Sr., M.D.
Gainesville

The FMA

The Ninetieth Annual Meeting of the Florida Medical Association has been laid to rest. As is the custom, an editorial postmortem is required. Organizationally, the convention functioned as well as its senile condition would permit. Those responsible for keeping it alive are to be congratulated.

Physicians, individually and collectively, are increasingly creatures of their social environment. A stiffening of our professional backbone is essential to our survival. This would permit us to react in an effective manner to the environment of a new socioeconomic and political world. The effect of the present state of affairs is strikingly revealed in the deliberations of the House of Delegates.

The social and political environment, as it affects medicine, should be defined and understood. Our social climate today results from a compromise at various ratio levels of "freedom from" as opposed to "freedom to." Economic and political slavery is the final goal of the "freedom from" philosophy. There seems to be a decline in the value put on individual freedom in our society.

Factors contributing to the regimentation of American society are the growing size and urbanization of our population, longevity of our citizens, rising crime rate accompanied by more rules and regulations, invasion of privacy by multiple agencies, growing centralization of government associated with bureaucratic control of local affairs, and, finally, a dossier mentality developed in our male population during World War II.

No one has greater admiration than I for the physician who still considers the practice of medicine a private affair between himself and his patient. Can physicians of this persuasion survive in our present social order? Can enough of these physicians be preserved to alter the events leading to the last day of complete loss of medical freedom? The pages of history clearly show what happens to physicians in other nations who are not sufficiently active in opposing attempts to regulate and control the practice of medicine. Dr. Annis, in his address to the convention, contrasted the European and American attitude toward medical care. The difference: community volunteerism versus compulsion. Because of a feeling of futility and apathy, the American doctor constitutes the greatest threat to his own future security and welfare. There would be no regulation of medicine now if there were no doctors begging to be regulated (and compensated) or rather, begging to be permitted to regulate. Many individual doctor's rights have been sold by him and he has received payment and he is unlikely ever to regain them.

It is erroneous to assume that the federal government is always the chief villain in creating the new medical environment. The interposition of the economic third party between the physician and his patient was not introduced by government but by industry. Management sees the cost of medical care as a significant budgetary item; labor—a fringe benefit; and, the politician—a free government service to be used to buy votes. All these agencies find it desirable to have a standard fee and a standard service. This, of course, cannot be accomplished without regulation of the physician.

Statistically, the percentage of the medical care dollar received by the physician for his services is rapidly diminishing. The expanding army of paramedical professions and the gigantic expansion of hospital facilities with its army of lay and medical administrators are challenging the practicing physician's role as the captain of the medical team. There are many other agencies and factors in our American economy that tend to subvert the physician's rightful role in society and threaten the quality of medical care.

The Florida Medical Association should be geared to meet these challenges through better education of the physician in the areas of economics, politics, and public relations, which can be effectively applied at the "grass root" or physician-patient level.

If the FMA is to become effective and vital, it should undertake some severe reorganization. First, the business must be put in the hands of able executives. These may, but probably will not be physicians. The physicians must be limited to (a) electing a board of directors to employ executives, (b) setting the policies under which they will operate, and (c) providing the mechanics to enforce these policies. Second, the Association must be given adequate financial resources with which to operate. This means a substantial increase in dues. Each doctor must know that he has some voice in setting policy but that once it is set, he must support it unconditionally.

Where does an active, practicing physician find the time really to operate organizationally and politically? Does anyone expect the officials of the Teamsters Union to carry on union affairs after they have come in from a long hard day on the highway with a multiton truck?

Nothing in the very narrow training of today's physicians has qualified them in management, politics, economics, administration, or government, yet it is a rare doctor who does not express the feeling that he is an expert in all these fields. A ludicrous sight, if one wishes support of this view, is the business session of any medical group wallowing through routine business matters. With courage matched only by their ignorance, they wade into legal, public relations and other highly technical matters with all the self confidence that is carefully acquired and displayed in the consultation room and over the hospital bed.

The FMA expects loyalty and discipline from its component societies. Its leaders are subjected to abuse and harassment from every self-qualified expert who cares to scourge them for any action they have taken. The Association carries on this charade of democracy, suffering from all its ills, but profits from none of the strength of this system. It attempts to do so with little money and in the spare time which its officers find after they have completed their busy day's practice. Its officers try to do these things well, and in competition with experts, without training or experience in these various fields. Why would not anyone who really believes in medicine's cause be discouraged and overwhelmed with a sense of futility?

The FMA convention can be more effective as an instrument to further the educational and organizational needs of the physician. Education in the science of medicine is well served by the specialty meetings. General scientific sessions should be eliminated and replaced by workshops in the fields of economics, public relations and the mechanics of politics given by experts in these fields for the purpose of making the individual physician effective through political action at the "grass root" or patient-physician level. An interim meeting of the House of Delegates in various parts of the state would permit more physicians to participate in the affairs of the Association.

Will the physicians of Florida ever become a part of an effective organization to meet the challenge of our new environment? Or—will we continue to look after our individual interests, express our uninformed extemporaneous opinions freely, exercise every possible "freedom from" and try to make the best individual deal we can with those who are rapidly acquiring control over us?

Millard B. White, M.D.
Sarasota

Ninetieth Annual Meeting Scientific Program

The programs for the Scientific Section Meetings of the Florida Medical Association are prepared by the Scientific Council. This is a difficult and demanding task requiring many hours of hard work beginning at the conclusion of each Annual Meeting and ending one year later. The programs for the Ninetieth Annual Meeting in Hollywood were stimulating, varied in subject material, well presented and, as usual, very poorly attended.

The papers presented were well divided between member and guest speakers. In this regard, Dr. Warren R. Guild of Boston was heard to comment on the excellence of the subject matter and authoritative manner of presentation by our member speakers. He was particularly impressed by the apparent good working and teaching relationship between the two medical schools in the state and the practicing physicians. Apparently panels composed of teaching doctors and working doctors are unusual in his state because of the ivory tower attitude of the former. The out-of-state speakers were certainly well chosen and added a good sense of balance to the programs on which they appeared.

Attendance at the sessions was uniformly poor. Most of the meetings opened with less than 100 in the audience and, in several instances, fewer than 50 were present. The audience usually increased gradually during the presentation of the individual papers with little turnover until the

beginning of the panel discussions. There was a rapid thinning of the audience before most panels. The exceptions to this chain of events were the programs on "Pyelonephritis" and "Functional Disorders of the Gastrointestinal Tract." Both of these assemblies were attended by an alert and receptive group who came and stayed for the entire program. In my opinion, these two sessions were the highlights of the meeting and this opinion seemed to be shared by the audiences.

The panel discussions were generally good, but usually not as good as the individual papers. The quality of the panels was determined by the moderator. Those moderators who edited the questions submitted by the audience, paced the discussions properly and answered some of the questions themselves were exceptional. Dr. Donald F. Marion and Dr. Richard C. Dever of Miami were both outstanding moderators.

A number of years ago there was an abrupt and regrettable shift of emphasis on state and county medical society programs from scientific topics to political and economic matters. This change is exemplified by the inclusion of one entire afternoon of medical economics as a part of the Scientific Section Meetings. This particular session was one of the most poorly attended and probably should not have been included in the scientific meetings. One cannot help but suggest the improvement that would occur if the time and effort devoted to formulation and revision of fee schedules, meetings with representatives of insurance companies and lobbying for state and national legislation were devoted to planning and preparing our next scientific program.

Many members of the Association who attended no scientific meetings other than their specialty meetings were asked why they did not attend the Scientific Section Meetings. Most of these replied, in effect, that the meetings are never any good. This attitude seems to be widely prevalent and traditional. It is probably the greatest problem facing the Scientific Council in its attempt to increase the attendance at the sessions. It may take heart from the indisputable fact that physicians are eager to continue their education and will choose to go to scientific meetings in the face of competing temptation if intellectually challenging topics are presented. The tradition of poor programs can be overcome by a continued presentation of good programs such as we have just experienced. If the program is good, people will come.

George H. McSwain, M.D.
Daytona Beach

Deaths

Murphey, David Rhodin Jr., Tampa; born in Anniston, Ala., on July 27, 1906; Vanderbilt University School of Medicine, 1930; from 1930 to 1935 served an internship and two residencies at the University of Virginia School of Medicine, was a fellow in surgical pathology there and at Johns Hopkins Hospital, Baltimore, and was a fellow at Kelly Hospital, Baltimore, and Memorial Hospital for the Treatment of Cancer and Allied Diseases, New York City; entered the private practice of surgery and gynecology in Tampa in 1935; was a veteran of World War II, serving from 1942 to 1946 in the Medical Corps of the United States Air Force with the rank of lieutenant colonel; was a past president of the Hillsborough County Medical Association; served on the Board of Governors of the Florida Medical Association for four years before becoming President-Elect of the Association in 1950 and President in 1951; was medical director of the Hillsborough County Civil Defense Commission and a past president of the Florida Blood Bank Association; was particularly active in establishing the Southwest Florida Blood Bank, prior to World War II; was certified by the American Board of Surgery; held membership in the American Medical Association, Southern Medical Association, American College of Surgeons, Southern Surgical Association, Southeastern Surgical Congress, American Association of Railroad Surgeons, Association of Seaboard Surgeons, Florida Association of General Surgeons, Society of Head and Neck Surgeons, and Southern Surgeons Club, of which he was president in 1960; died May 16, aged 57.

Richardson, Shaler Arnold, Jacksonville; born in Lake Charles, La., on Feb. 27, 1891; Vanderbilt University School of Medicine, 1913; served a two year internship at Memphis City Hospital, Memphis, Tenn.; entered the Medical Corps of the United States Army during World War I, serving from 1917 to 1919, attaining the rank of major; upon conclusion of his military duty, was for four years resident physician at the New York Eye and Ear Infirmary; since 1922 had engaged in the private practice of ophthalmology in Jacksonville; held membership in the Florida Medical Association for 47 years, filled numerous committee assignments, served as its Secretary-Treasurer and Editor of The Journal of the Florida Medical Association from 1925 to 1944 when he became President-Elect for two war years, was its President in 1946, resumed the post of Editor of The Journal in 1947, was named Editor Emeritus in 1961 and continued to serve in that capacity until his death; also in 1961, was awarded the Association's highest honor, its Certificate of Merit; was a leading figure statewide in every type of work for the blind; was a charter member and past president of the Florida Society of Ophthalmology and Otolaryngology; was chief of service for ophthalmology at St. Luke's, St. Vincent's and Riverside Hospitals and consulting ophthalmologist at Duval Medical Center and at Flagler Hospital in St. Augustine; at one time served as clinical professor of ophthalmology at the University of Florida College of Medicine, Gainesville, and chairman of the section on ophthalmology of that institution's Postgraduate Medical School; was a member of the advisory board, Florida Council for the Blind; had been chief ophthalmologist of the Florida State Welfare Board since 1945; was a former member and past president of the Florida State Board of Health; was a member and a past president of the Duval County Medical Society; was a diplomate of the American Board of Ophthalmology and a fellow of the American College of Surgeons and the American Academy of Ophthalmology and Otolaryngology; held membership in the American Ophthalmological Society; was a member of the American Medical Association and the Southern Medical Association and was a past chairman of the latter organization's section on ophthalmology; died May 27, aged 73, following a heart attack.

White, Herbert Eugene, St. Augustine; born in Flovilla, Ga., on Oct. 28, 1897; Emory University School of Medicine, Atlanta, Ga., 1923; served an internship and a residency at Grady Memorial Hospital, Atlanta; since 1925 had engaged in the practice of general surgery and obstetrics in St. Augustine; was chief of staff of Flagler Hospital from 1935 until he resigned in 1963; served the St. Johns County Medical Society as secretary, treasurer, vice president and president prior to 1946 and from 1950 to 1960 was chairman of its legislative committee; was a life member of the Florida Medical Association, having served as a Councilor and chairman of the Council, as chairman of the Committee on Legislation and the Committee on Scientific Work, as First Vice President, President-Elect and in 1950 President; was a past president of the Chattahoochee Valley Medical Society; was a member of the American Medical Association, Southern Medical Association, American College of Surgeons, International College of Surgeons and Southeastern Surgical Congress; died May 11, aged 66.



Clinical Comment



General Practice

The Fourteenth Annual Scientific Assembly of the Florida Academy of General Practice, held in Lakeland last October, offered a record of 16 postgraduate credit hours for attending the lectures of 28 clinician-researchers. The program for the three day Assembly consisted of five individual topics and six seminars of two hours each devoted to problems and management of pediatrics, teenage deportment, geriatrics, current research, lipid metabolism and surgery. Nineteen seniors of the University of Florida College of Medicine were guests of the Academy for the meeting, an innovation which proved so fruitful that it will be repeated in future.

From the wealth of material presented, the opening seminar on "The Orbiting Teenager" was selected for review. The discussants were Drs. Paul L. Adams, John J. Schwab and David R. Offord from the Department of Psychiatry of the University of Florida College of Medicine and Dr. Ben J. Sheppard, pediatrician and Judge of the Dade County Juvenile and Domestic Relations Court. The symposium, held in the Annie Pfeiffer Chapel of Florida Southern College, was attended by faculty members from high schools and colleges in the Polk County area.

"Understanding the Emotions of the Teenager" was the subject presented by Dr. Schwab. The teenager, he pointed out, has a special concept of time and place. Early he seeks emancipation and independence from his parents in order to assert his own standards, frequently belittling them vehemently, thoughtlessly and, too often, cruelly. Among his fellow teenagers he is a strict conformist, unwilling to disagree in thinking, deportment or dress lest he risk unpopularity and ostracism. His schooling is more important to him than his parents realize, and they should voice more frequently sincere appreciation of his efforts. "Alas, parental time and adolescent time are not measured from identical biological clocks," commented Dr. Schwab. "The teenager has a sense of immediacy which climaxes in his desire 'to try his wings now.'" He described the critical period of adolescence as the age of opportunity and emphasized the often overlooked value of praise. Chapman's famous three L's he regarded as still applicable to parents, "Love them, limit them, but let them grow up!"

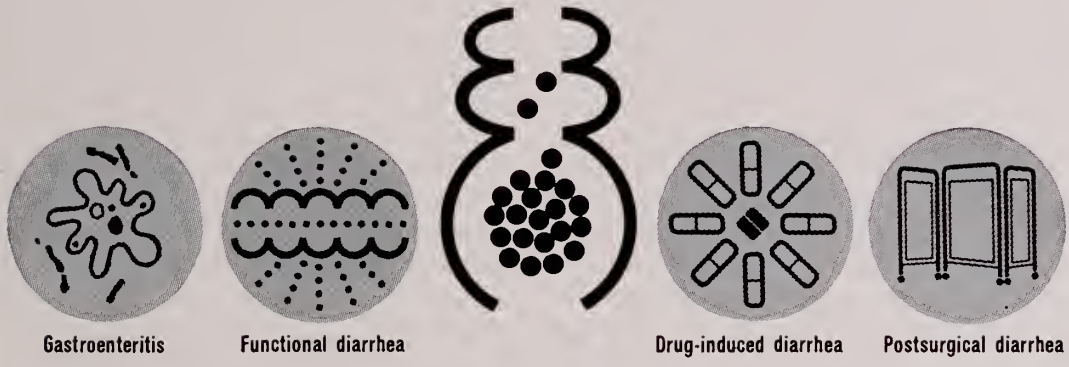
Speaking on "Problems With Smoking, Alcohol and Drug Abuse," Dr. Offord declared that these three ogres besmirching adolescence are often rooted in a scarred childhood, only to blossom forth in the teens. Teenagers adopt smoking, alcohol and drug abuse to deal with their own uncomfortable feelings: anxiety, anger, depression and inferiority. One in two high school seniors is a "regular" smoker. If both parents smoke, one in three children will smoke; if only one parent smokes, one in four children will smoke; if neither parent smokes, the rate drops to one in six. Smoking habits are higher among students who are scholastically inferior and who participate least in extracurricular activities. The physiologic damage that may be caused by chronic smoking should be explained to students in the seventh grade and higher, Dr. Offord said, but they should be permitted to form their own conclusions.

Junior's alcohol pattern usually begins by mimicking the social pattern of his parents. By the time they reach the tenth grade, one in every two boys and one in every five girls has been introduced to alcohol. Teenagers favor "party-type" drinking, seeking to prove they belong to, or conform with, a peer group. In addition, they drink to reduce tensions, to prove manliness, or to help "sow wild oats." The teenager drug addict, in contrast, in a sick, infantile, agitated person whose difficulties relate back to a long history of social and emotional malajustments. Coming from an environment of deprivation and often a member of a racial minority, he copies his parents by approaching life with inadequacy, frustration and helplessness and often isolates himself or associates with delinquents and truants. Recovery is poor or slow, at best, because he faces

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Research in the Service of Medicine SEARLE

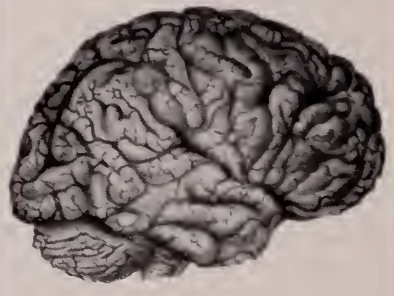
treatment without motivation, convinced that the drug he craves has a calming, pleasurable effect on him.

In his discussion of "Problems of Dating, Petting, and Sex," Dr. Adams declared that sexual preoccupations of the usual adolescent are more intense than those of the usual child, but much less intense than those of the usual adult. The teenager is truly a "Mr. In-Between," whether in physique, sexiness, or other biological traits. Adolescence, he said, is notorious for identity problems, not sexual problems, and sexual excesses occurring in adolescence are neurotic patterns as are also sexual inhibitions and denials of sexual feelings. The teenager is concerned primarily with who he is, how he relates to this world and what he stands for in his society. The oversexed teenager is usually a compulsive individual, trying to prove his adequacy. He is performing, not loving, and is trying "to comply with an idealized image of potency and manhood"—and is doing so neurotically. The 15 year old who is beset with sexual inhibitions and who ruminates all day about sex to prove his, or her, concept of adulthood faces a real threat to mental health. The teenager should normally move toward a "sound heterosexual orientation," which by no means implies that he must be steeped in so-called romantic love. His concept of words differs from that of adults with reference to boy-girl social relations." By the time young people move beyond adolescence," Dr. Adams summarized. "Sex should be a mellower business, ready for the acceptance and integrity into the totality of a full and balanced life."

Judge Sheppard, whose court settles over 10,000 cases a year involving 14,000 children, contended that delinquency breeds where the family structure has broken down. Although many thousands of Cubans have recently settled in Dade County, Florida, it is noteworthy that no case of delinquency has come before Judge Sheppard from this displaced group. He attributed this excellent record to the better class of Cubans who escaped to Florida and to the stronger concept of a family unit among these people. One in five of Dade County's school population of 200,000 is of the Negro race; yet one in three of this group is a delinquent appearing before Judge Sheppard for felonies such as shoplifting, truancy, violence or even rape. He deplored Florida's rank of forty-first among the states regarding the level of teachers' salaries, and also the heavy turnover

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of Florida teachers in certain counties. "Give me a good home room teacher," he said, "and I do not need a psychologist." Good dedicated teachers, he asserted, would insure better instruction, better children and better communities. He is a strong proponent of Dade County's Mark Plan, an experiment in approximately 20 schools which permits parents, or elders, to join in school activtities after 5 p.m. "By bringing parents into the community school system and permitting a closer association and a 'working-together' with their children," Dr. Sheppard observed, "there will result a more dependable child and a better community." Rather than permissiveness, he advised more restrictions on the ground that youngsters want to be directed and to be told what to do. He urged rebuilding the home as a family unit and letting children know that they are being loved.

Louis J. Polskin, M.D.
Scientific Program Chairman
Lakeland

The scientific exhibit presented by the Committee on Veterinary Medicine of the Florida Medical Association at the 90th Annual Meeting of the Association in Hollywood won the First Place Award. Dr. Clifford C. Snyder of Miami is Chairman of the Committee and serving with him were Drs. Joseph L. G. Lester Jr. of Key West, George W. Karelas of Newberry, Sidney Smith of Bradenton and Henry W. Shupe of Clewiston. Second Place Award went to the exhibit entitled "Common Problems in Otolaryngology," presented by Dr. John W. Stone of Lakeland. Dr. Raymond E. Parks of Miami was given the Third Place Award for his exhibit, "A Pilot Study in Mammography," and Drs. Richard G. Connar and Ralph C. Aye of Tampa the Fourth Place Award for their presentation entitled "Diagnostic Arteriography."

The Twelfth Annual Diabetes Seminar is being held at the Balmoral Hotel at Miami Beach Sept. 30-Oct. 2. It is presented by the Florida Diabetes Association and the Florida State Board of Health in cooperation with the University of



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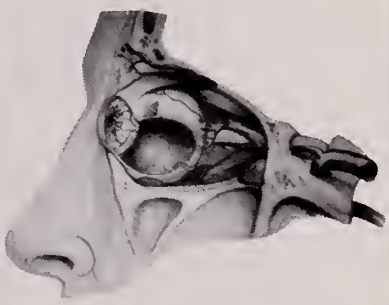
decreases resistance in arteries and arterioles in skeletal muscle, in the brain, and possibly in the eye and inner ear • increases cardiac output (minute stroke volume) without significant changes in pulse rate or blood pressure • especially useful in enhancing blood flow in ischemic tissues • essentially safe, well tolerated, with rapid and sustained response • economical

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The Fourteenth Annual Postgraduate Obstetric-Pediatric Seminar is being held at the Daytona Plaza Hotel at Daytona Beach on August 20-21.

Dr. Paul S. Jarrett of Miami won the first award for attendance at the Technical Exhibits of the 90th Annual Meeting of the Florida Medical Association held in Hollywood. Dr. John B. Henry of Gainesville won the second award, and Dr. Chester M. Askue of Port Charlotte the third award.

Dr. Richard L. Smith of Coral Gables was awarded the Orlando Loving Cup for low gross at the annual Florida Medical Association Golf Tournament held at the New Presidential Country Club at Hollywood during the Annual Meeting of the Association. The Duval County Medical Society trophy for low net was presented to Dr. James F. Gallagher Jr. of Miami Shores.

An interesting and up-to-date discussion of "Serological Tests for Syphilis and Their Interpretation" was presented by Dr. M. B. Moore of the U. S. Public Health Service at the meeting of the Florida Health Officers' Society in Hollywood on May 9. The older tests were evaluated and a discussion followed on the efficiency and reliability of the many new tests. Other presentations included "Proposed Involuntary Commitment for Alcoholism" by the Honorable Mervin Rehrer of Sebring, Highlands County Judge, and "Comparison of Intradermal and Subcutaneous Injection of Influenza Vaccine" by Dr. T. Paul Haney of Titusville, Director of the Brevard County Health Department.

It is the intention of the Florida Chapter of the American College of Surgeons to contribute several special pages to The Journal of the Florida Medical Association. The articles should be 250 to 300 words in length and of scientific interest not only to the general surgeon but also to the various surgical specialties. Active members of the Florida Chapter are urged to contribute. Articles should be sent to Dr. Chas. Larsen Jr., President, Florida Chapter, American College of Surgeons, Watson Clinic, Lakeland.

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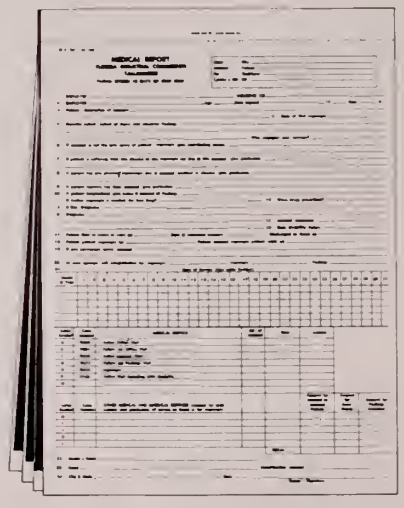
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1. Viglione, J.P.: Clin. Med. *69*:1157 (May) 1962.

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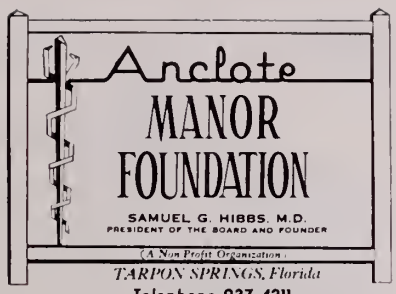
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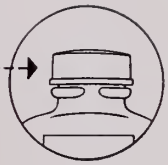
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Florida Specialty Societies			
Allergy Society	Morton L. Hammond, Miami	Woods A. Howard, Lakeland	
Anesthesiologists, Soc. of	Francis M. Coy, Jacksonville	John A. Rush, Jacksonville	
Chest Phys., Am. Coll. Fla. Chap.	Minas Joannides Jr., St. P'burg	Franklin G. Norris, Orlando	
Dermatology, Soc. of	Wm. H. Eyster Jr., Daytona Bch.	William W. Bruce, Winter Park	
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Neurosurgical Society	John M. Thompson, St. P'burg	Jack W. Barrett, Miami	
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Orthopedic Society	Theodore Norley, W. Palm Beach	Leon H. Mims Jr., Coral Gables	
Pathologists, Society of	Sanford A. Mullen, Jacksonville	Laudie E. McHenry Jr., Melbourne	
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Urological Society	John T. Karaphillis, Clearwater	Robert N. Webster, Tallahassee	
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Basic Science Exam. Board	P. A. Vestal, Winter Park	T. A. Ashford, Tampa	Tampa, Nov. 7, 1964
Blood Banks, Association	J. T. Branham, Orlando	Mary Rand, Orlando	
Blue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	H. A. Schroder, J'ville	November, 1964
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Cancer Council	Earl E. Wilkinson, Tallahassee	J. E. Fulghum, J'ville	Orlando, Oct. 17, '64
Diabetes Association	George F. Schmitt, Miami	Seymour Alterman, Miami Bch.	Miami Beach, Oct., '64
Dental Society, State	Richard C. Chace, Orlando	H. B. Pattishall Jr., J'ville	
Heart Association	W. Jape Taylor, Gainesville	T. L. Batchelder, J'ville	Orlando, May 1965
Hospital Association	M. T. Mustian, Gainesville	Willie G. Hinson, Marianna	November, 1964
Board of Medical Examiners	Courtlandt D. Berry, Orlando	Homer L. Pearson Jr., Miami	Orlando, Nov. 22-24, '64
Pharmaceutical Assn., State	Freeman C. Oikle, Miami	R. Q. Richards, Ft. Myers	Bal Harbour, May 16-19,
Public Health, Association	Harvey M. Burnett, J'ville	E. H. Williams Jr., J'ville	W. Palm Beach, Oct., 1-
Thoracic Society	A. E. Anderson Jr., J'ville	Mark W. Wolcott, Coral Gables	Miami, Apr. 23-24, '65
Tuberculosis & Res. Dis. Assn.	Harry Schnabel, Ponte Vedra	Mrs. D. Milberger, Gr. Cove Sprgs.	
Woman's Auxiliary	Mrs. W. L. Fitzgerald, Miami	Mrs. R. B. Carson, Ft. Lauderdale	Bal Harbour, Apr. 21-25,
American Medical Association	Norman A. Welch, Boston	F. J. L. Blasingame, Chicago	New York, June 20-24, '
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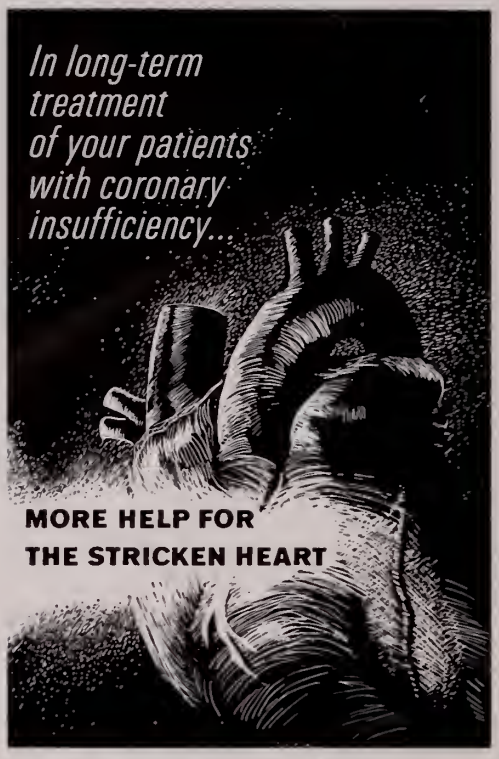
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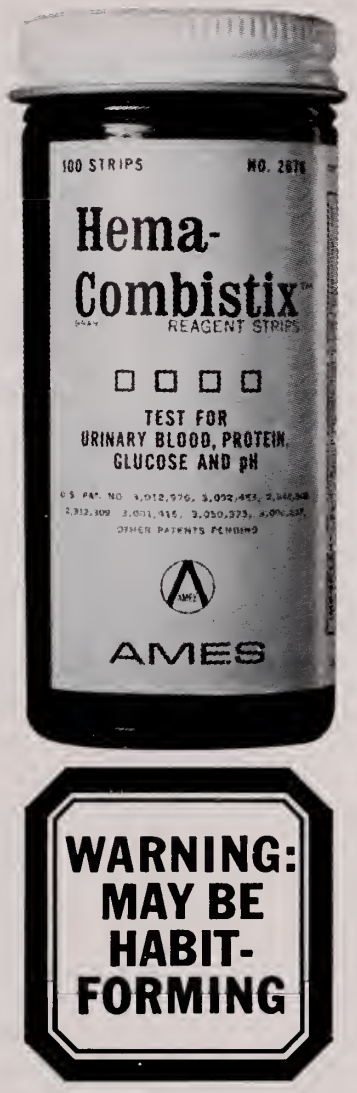
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Volume 51, Number 8, August 1964

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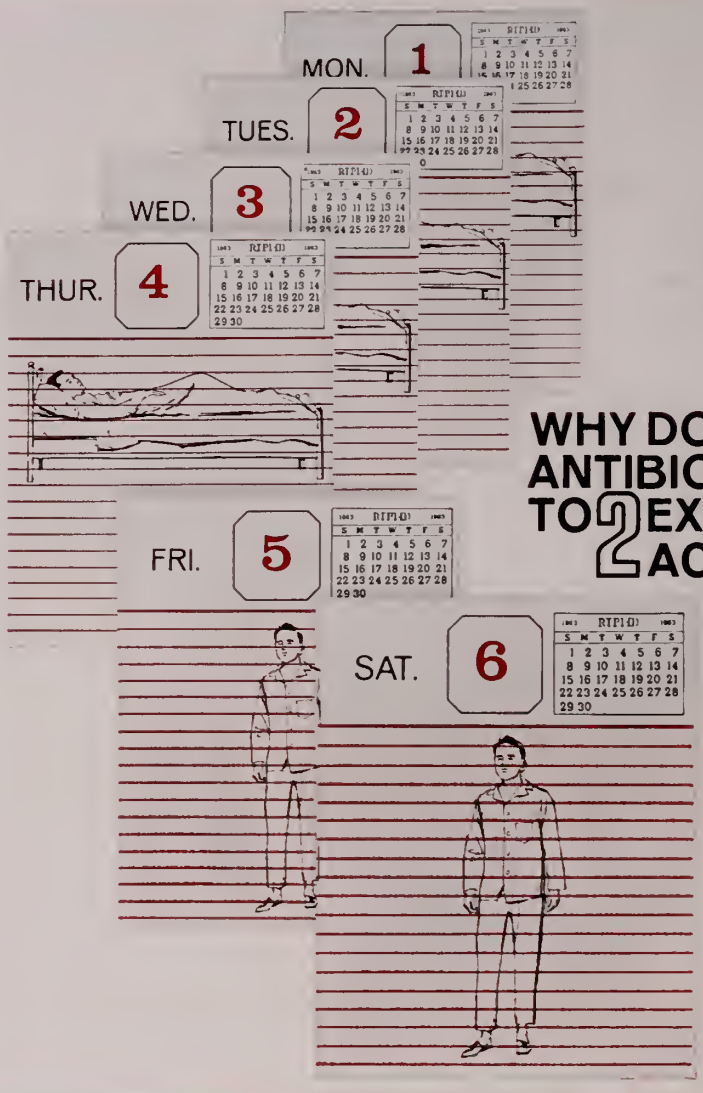
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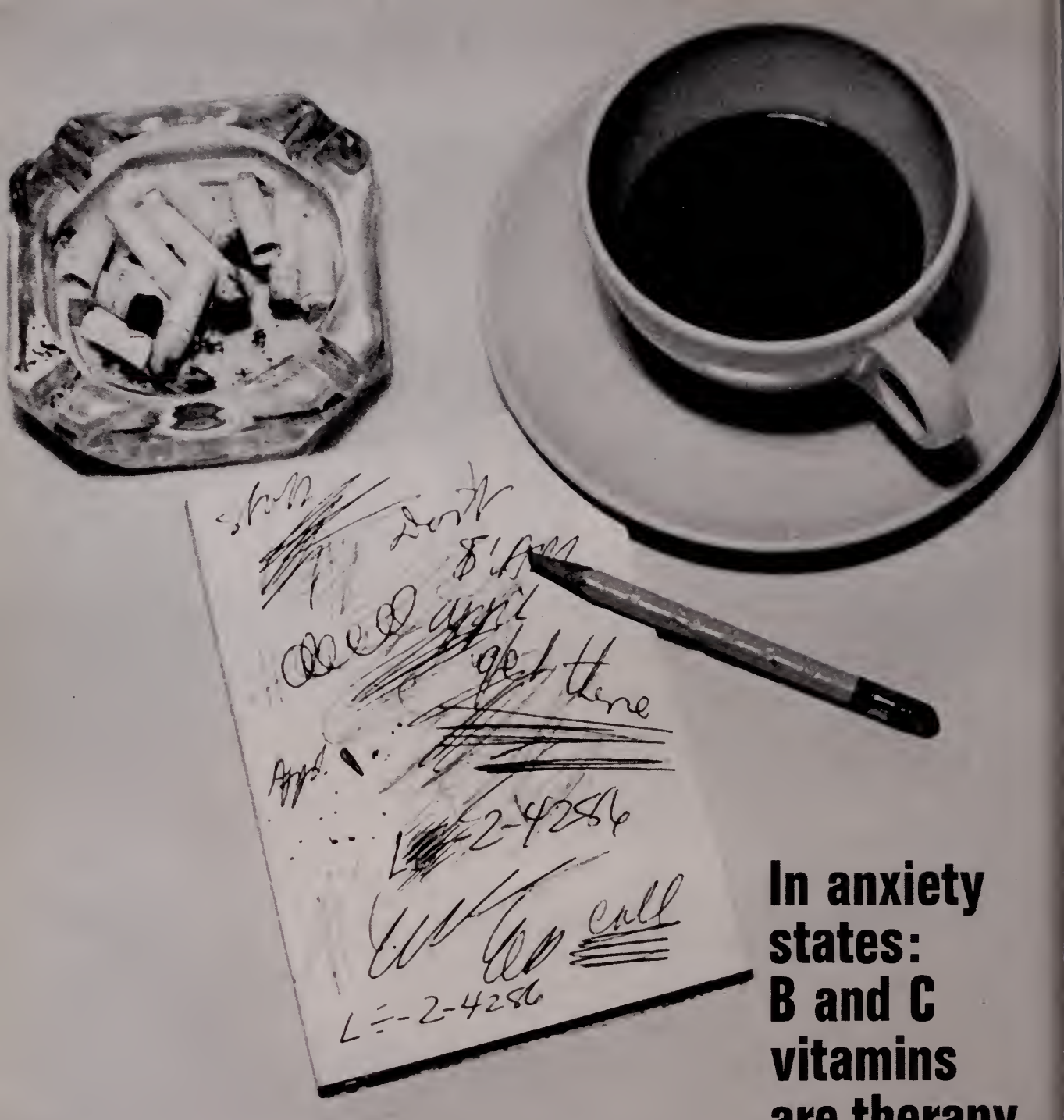
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*Cohen, et al: J.A.M.A., 165:225, 1957.

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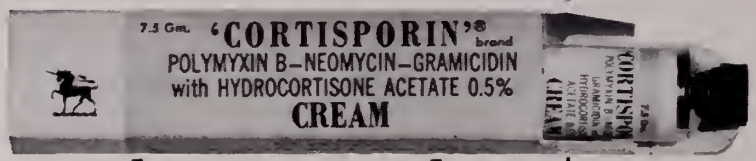
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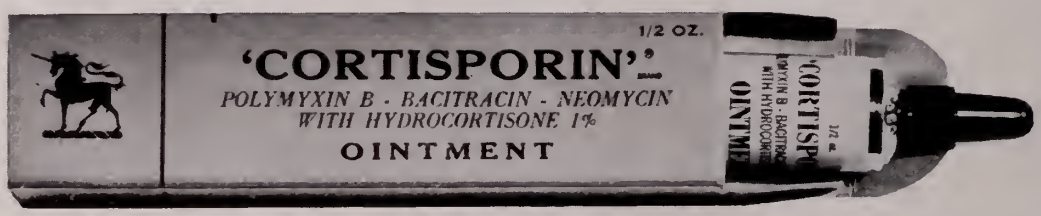


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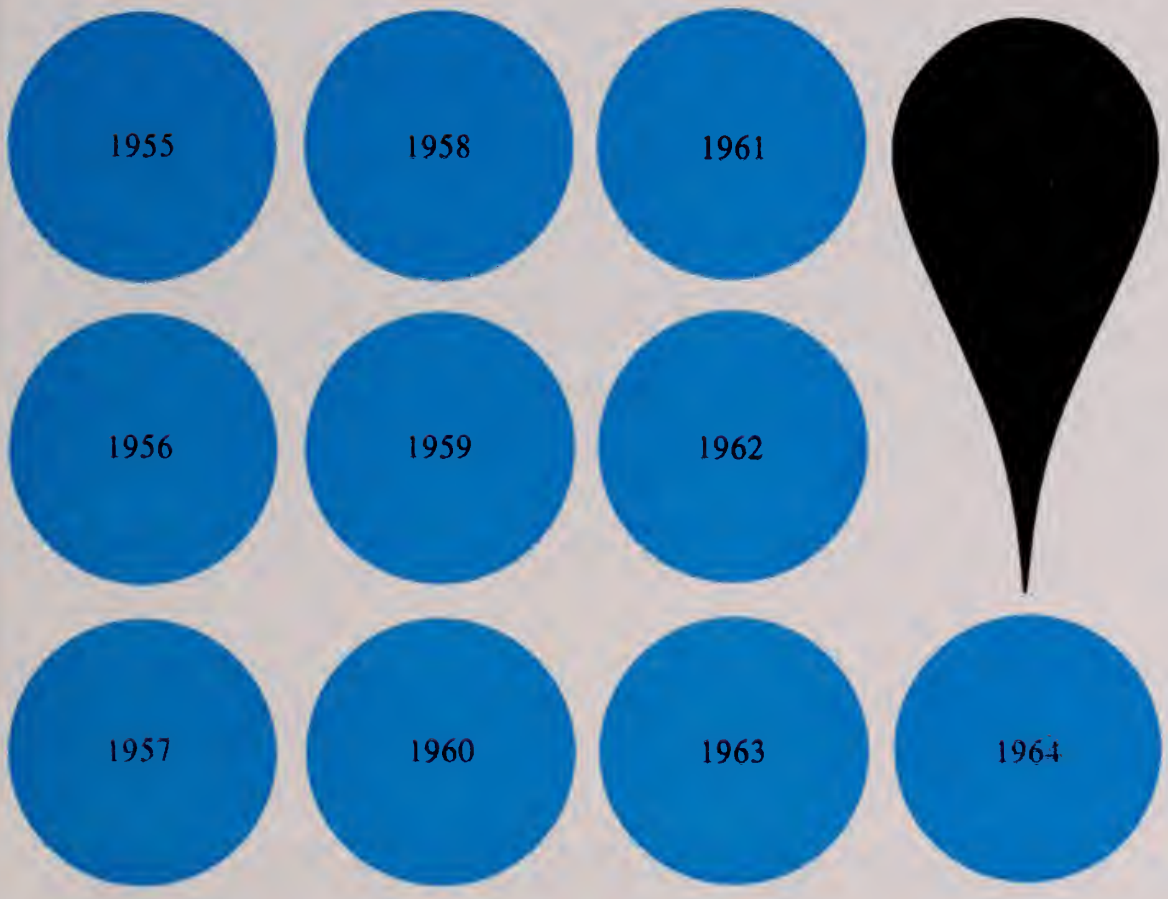
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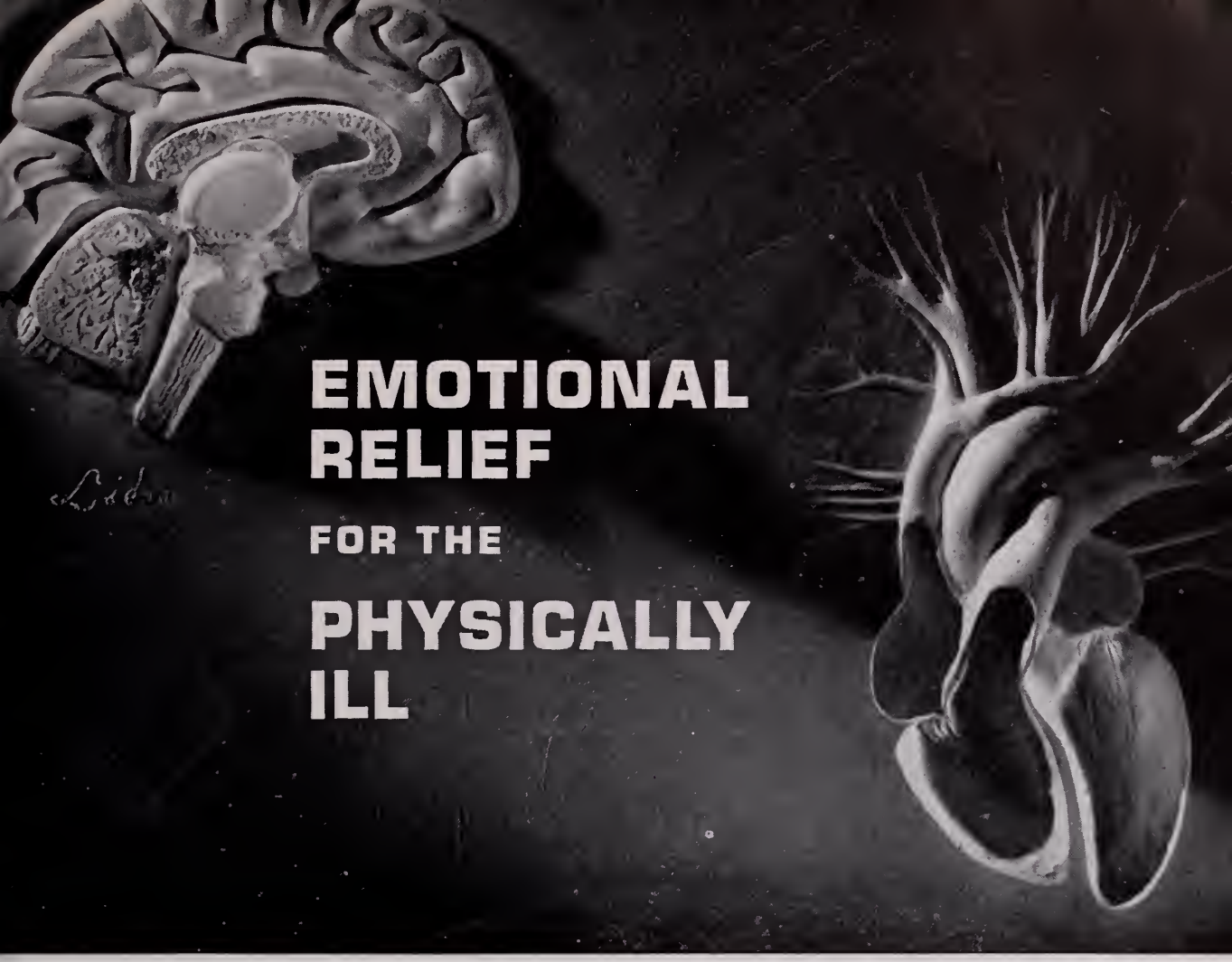
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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).



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The JOURNAL
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The August Issue Features Broward County Medical Association

This is the third issue of The Journal to be devoted to scientific presentations and editorials by the members of a component county medical society of the Florida Medical Association. In February 1963, the members of the Brevard County Medical Society furnished material for an issue and a year later, in February 1964, the Marion County Medical Society was featured.

This month we are pleased to present material by members of the Broward County Medical Association and to congratulate Dr. David J. Lehman Jr. of Hollywood who has served as guest editor. He has reviewed each of the scientific articles and has graciously and competently rendered the service necessary in gathering material for a special issue.

We offer this issue as an additional challenge to the members of other county medical societies to share their scientific interests and editorial ability with the entire membership of the Florida Medical Association.

T.M.

Chronic Idiopathic Myocarditis

STANLEY S. GOODMAN, M.D.
FORT LAUDERDALE

Chronic idiopathic myocarditis is a disease, or perhaps a group of diseases, that has gone under a variety of names. These include chronic myocarditis,[3] idiopathic cardiac hypertrophy,[7,26] pernicious myocarditis.[11] and isolated myocarditis.[1] This disease is characterized by severe progressive congestive heart failure, markedly enlarged heart and diffuse myocardial hypertrophy with no apparent etiology and is usually fatal. It is one of a growing group of noncoronary myocardial abnormalities.[2] This paper reports my experience with this disease.

In the six cases presented the patients were seen at the Veterans' Administration Hospital, Coral Gables, during the years 1960 and 1961. All of these patients had the features of severe congestive heart failure, enlarged heart and myocardial hyperthrophy, without evidence of coronary artery disease, hypertension or avitaminosis. In all of the cases an autopsy was performed.

Clinical Findings

Table 1 presents some of the more important findings in these cases. Certain features are worthy of note. The duration of illness from the first symptom to death ranges from two months to eight years. There has been little reference in the literature to the long duration of illness in some cases.

Fever preceded or accompanied the onset of illness in two cases. In two others fever during the illness may or may not have been related. Chest pain, usually anginal in character, occurred in three cases. Because of this pain and ST-T changes in the electrocardiogram, in these three and one additional case a diagnosis of myocardial infarction was made.

Physical findings included the usual signs of severe congestive heart failure. Heart sounds were noted to be "distant" in three cases and a diastolic gallop was present in two cases, at least at some time during the illness. A systolic apical murmur was present in one case and a diastolic murmur in one. Cardiac arrhythmias have been frequently described in this syndrome.[7,11,12,22,26] In five cases significant arrhythmias occurred at least at some time during the illness (table 2). Blood pressure and pulse pressure were normal in all six cases. Pericarditis as evidenced by a friction rub occurred in two cases, but lasted only a few hours in both. In two other cases a pericardial infiltrate was noted at postmortem which resembled that seen in old pericarditis.

The routine laboratory tests were generally normal. There was no consistent alteration in the blood count, blood sugar, blood urea nitrogen, cholesterol, or LE cell preparations. The serum glutamic oxaloacetic transaminase was abnormal in three cases: the level was greater than 1,000 in two of these. These elevations were transient and did not appear at any characteristic time during the disease. In one patient, a serum glutamic oxaloacetic transaminase level of 2,000 occurred during an episode of paroxysmal rapid atrial fibrillation and acute congestive failure. Two others were in chronic congestive failure at the time. Three patients had marked derangement of liver function with a bilirubin concentration greater than 3 mg. and prothrombin times greater than 20 seconds. Two others had bilirubin values between 1.5 and 3 mg. Liver derangements in this range can develop in patients in congestive failure due to arteriosclerotic rheumatic heart disease, but they are by no means common.[19] Moreover, in arteriosclerotic or rheumatic heart disease this degree of liver derangement occurs only after severe and long-standing failure. The severity of hepatic dysfunction seems to be a feature of this disease. Thromboembolic phenomena occurred in three patients. One of these was a paradoxical embolus to the coronary artery via a patent foramen ovale, resulting in myocardial infarction and death. The other two were pulmonary infarctions recorded at autopsy. In one of these cases a thrombus was present in the right atrium. Peripheral emboli are not common in prolonged failure without atrial fibrillation or myocardial infarction, but are common in this syndrome.

The electrocardiographic findings were nonspecific (table 2). The electrical axis was often aberrant. Arrhythmias and bundle branch blocks were common. The P-R interval and QT ratio were normal in all cases. Nonspecific ST-T wave changes occurred at some time during the disease. The QR-S voltage in the precordial leads was usually normal, but the voltage recorded in the

Table 1. — Clinical Findings

Patients	1	2	3	4	5	6
Age and race	47 W	34 W	29 W	46 W	40 W	66 N
Duration of illness	2 mos.	3 mos.	6 mos.	3 yrs.	4 yrs.	8 yrs.
Fever before onset		+	?	+		
Chest pain	+			++	++	
Arrhythmias	+	+		+	+	+
Gallop rhythm	+		+			
Heart murmurs			S			D
Pericarditis		+	?	*		*
Clinical diagnosis of myocardial infarct		?		+	+	
Liver function abnormalities	++	++	+		+	++
Prothrombin time (sec.)	24	20	15	13		20
Serum glutamic oxaloacetic transaminase	30	2,000	1,000		160	40
Steroid treatment			+	+		
Heart weight (Gm.)	460	580	500	650	640	710
Thromboembolism			Coronary		Pulmonary	Pulmonary
Associated illnesses	Tuberculosis	Diabetes Ataxia Influenza	Trauma	Emphysema Influenza	Diabetes Trauma	Positive serological test for Syphilis

*Microscopic evidence at autopsy.
+Bilirubin 1.5 to 3.0 mg.
++Bilirubin above 3.0 mg.

standard leads was often low. In five cases there was a maximum reflection in the standard leads of less than 6 mm. A prominent P wave was noted in one case.

The chest x-rays were characterized by diffusely enlarged hearts. In two of these cases, rapid growth in the size of the heart was noted within a few months prior to death.

In addition to the myocardial disease, the following conditions occurred in these patients: One patient each had pulmonary tuberculosis, pulmonary emphysema and a positive serological test for syphilis with negative spinal fluid. One patient had diabetes and spinal ataxia, which did not have the features of Friedreich's ataxia. In two cases trauma was involved. In one case a minor blow to the chest was followed by the onset of angina and the beginning of a four year illness. The patient also had mild diabetes. In the other cases a fracture of the odontoid process was present, but no history of chest trauma could be elicited.

Reference is made to Gall's case, which is similar in that minor chest trauma appears to make apparent a myocarditis. Pathological study of this case, in which the patient died within a short time of the onset of the trauma, showed a diffuse interstitial fibrosis. Moritz also commented on the difficulties of establishing the relationship of heart disease to trauma.

Discussion

The clinical picture in the cases presented does not differ markedly from that presented by others.[2,7,11,13,26] It is dominated by the occurrence in relatively young persons of severe progressive intractable heart failure, marked enlargement of the heart, multiple arrhythmias, bizarre electrocardiographic changes and thromboembolic episodes.

Certain features of these cases have not been frequently noted in the literature. Pericarditis occurred in four cases. In two of these, transient friction rubs were noted and in the other two microscopic evidence of previous pericarditis was obtained at autopsy. Chest pain resembling angina may be severe. Its occurrence in the presence of ST-T wave change in the electrocardiogram may lead to a diagnosis of myocardial infarction. This disease can occur in older persons. The oldest patient in this series was 66 years of age. It is likely that when older persons have this disease in the presence of arteriosclerotic changes in the coronary vessels, the diagnosis of arteriosclerotic heart disease is made both clinically and at postmortem in preference to "idiopathic myocarditis."

The duration of the illness may be long or short. The longest duration was eight years. Marked elevations in serum glutamic oxaloacetic transaminase (1,000) and severe abnormalities of

Table 2. — Electrocardiographic Findings

Case	A QRS	QRS Voltage Standard Leads	ST Changes	T Wave	Rhythm	Diagnosis
1	-90	5 mm.	Flattened V 4-6	Inverted II, III, AVF, V 4-6	Atrial fibrillation Regular sinus rhythm Electrical alternans of T	Myocardial ischemia Suggestive of cor pulmonale Nonspecific ST-T changes
2	-150	3 mm.	Flattened II, III, AVF, V 4-6	Digitalis effect	Rapid atrial fibrillation with premature ventricular contractions Regular sinus rhythm with premature ventricular contractions Ventricular tachycardia Incomplete right bundle branch block Slow atrial fibrillation	Subendocardial ischemia
3	90	4 mm.	Elevated V 2-4 Depressed V 4-6	Flat I, II, III, AVL, AVF Inverted V 4-6	Sinus tachycardia	Subendocardial ischemia Acute anteroseptal infarct
4		5 mm.	Elevated II, III, AVF	Reciprocal to left bundle branch block	Sinus tachycardia	Left bundle branch block complete Suggestive of cor pulmonale
5		10 mm.	Depressed I, AVL, V 5-6	Reciprocal to left bundle branch block	Atrial fibrillation Regular sinus rhythm	Complete left bundle branch block Subendocardial ischemia Left ventricular hypertrophy
6	120	6 mm.	Elevated V 2-4	Flat III Inverted AVF	Atrial fibrillation Regular sinus rhythm with frequent premature ventricular contractions	Right ventricular hypertrophy Digitalis effect

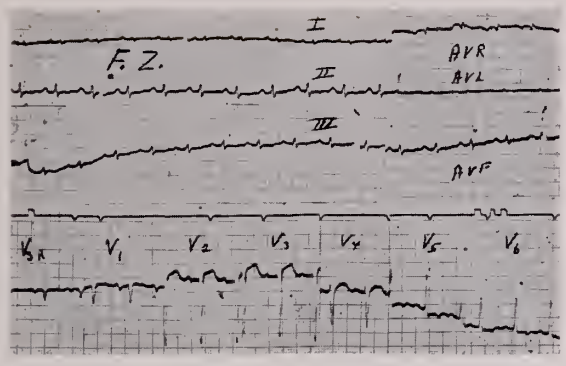


Fig. 1.—This electrocardiogram shows the arrhythmia, low voltage and unusual electrical axis (-150) which are some of the features of this disease. See table 2.

liver chemistry occurred more frequently than one usually sees in congestive heart failure of other etiologies.[19]

The pathological picture of the heart in this series is dominated by muscular hypertrophy and diffuse interstitial fibrosis. There was little in the way of cellular infiltrate. Some cases showed small foci of lymphocytes. Degenerative changes of a fatty type occurred in only one case (case 3). It would appear that the amount of cellular infiltrate may vary considerably. There is some indication that in these cases it was roughly inversely related to the duration of the illness.

The findings of pericarditis and fever suggest the possibility that despite the absence of cellular infiltration this is an inflammatory disease.

Comment

The syndrome of chronic idiopathic myocarditis is part of a large group of primary myocardial abnormalitis. Table 3 represents a classification of these noncoronary conditions. In group V has been placed a group of idiopathic myocardial diseases some of which have certain features in common. Fiedler's myocarditis is a clinical description of an acute myocarditis usually terminating in a few weeks. It is not, at least as described by Fiedler, a single etiological entity.[23] The myocardial disease of pregnancy consists of congestive heart failure and an enlarged heart occurring in association with pregnancy. It appears more benign than the cases here described. Those cases that have terminated fatally have presented a miscroscopic picture of muscular hyptertrophy and interstitial fibrosis.[14]

Familial myocarditis is a similar clinical and pathological condition which occurs in families. It may be so benign that in some cases the patient leads a normal life.[17,18] Basophilic myocarditis is a type of myocardial degeneration. The clinical picture is characterized by congestive heart fail-



Fig. 2.—a. Typical x-ray shows a diffusely enlarged heart. b. Note also the rapid enlargement over a period of a few days.

Table 3. — Noncoronary Myocardial Abnormalities

I. Specific Myocarditis
 1. Rheumatic
 2. Syphilitic
 3. Sarcoid
 4. Tuberculosis

II. Associated with Infectious Disease (Direct or Toxic)
 1. Viral — influenza, Coxsackie poliomyelitis
 2. Bacterial — scarlet fever, diphtheria, typhoid fever
 3. Fungal — blastomycosis
 4. Protozoan — Chagas' disease

III. Collagen
 1. Hypersensitivity
 2. Systemic lupus, periarteritis

IV. Metabolic
 1. Beriberi
 2. Hyperthyroidism and hypothyroidism
 3. Amyloid
 4. Glycogen storage
 5. Associated with acromegaly[2]
 6. Alcohol
 7. Friedreich's ataxia
 8. Muscular dystrophy
 9. Hemochromatosis
 10. Heart failure of aged[20]

V. Idiopathic
 1. Granulomatous myocarditis
 2. Fiedler's myocarditis
 3. Heart failure of pregnancy
 4. Familial myocardial disease
 5. Myocarditis in infants
 6. Basophilic myocarditis
 7. Subacute or chronic "pernicious myocarditis," "idiopathic myocarditis," "idiopathic hypertrophy"

VI. Related Conditions
 Endocardial Disease
 1. Endocardial fibroelastosis of infancy
 2. Cardiovascular collagenosis (Becker's disease)
 3. Löffler's disease
 4. Endomyocardial fibrosis of Uganda
 5. Associated with carcinoid

ure and arrhythmias.[25] A diffuse myocardial disease occurs in infants and children which has a clinical picture similar to that of the other idiopathic myocardial abnormalities. In some of these cases the disease is undoubtedly viral in etiology.

The heart disease that occurs in association with Friedreich's ataxia has been included among the metabolic disorders. It may be asymptomatic or lead to death. Focal necroses, chronic interstitial myocarditis and hypertrophy of the muscle fibers have been demonstrated at autopsy.[9,21]

The etiology of chronic idiopathic myocarditis is, of course, obscure. The possibilities of viral disease, metabolic disturbance, hypoxia and other conditions have all been discussed by various authors[2,7,11,13,26,29] without definite conclusion.

The antemortem diagnosis of chronic idiopathic myocarditis is difficult. The major differential diagnoses are arteriosclerotic heart disease, subendocardial fibroelastosis, and a specific myocarditis such as Chagas' myocarditis or rheumatic myocarditis. Even the most careful clinical evaluation may not make the diagnosis evident.[4] Once the suspicion of this disease is raised, however, more definitive procedures may be employed. Coronary angiography may be helpful in evaluating the possibility of arteriosclerotic heart disease. Angiocardiography may be helpful in fibroelastosis if the typical "onion skin" appearance is demonstrated.[30] Cardiac muscle biopsy would probably be most specific in defining the status of the myocardium.

Therapy in these cases has been generally unrewarding. Initially it is possible to control the congestive failure with digitalis, diuretics and other measures. Steroids were used without success in two cases of the present series. Burch[3] suggested prolonged bed rest for 10 to 19 months which appeared to be of benefit in a few cases which on a clinical basis were diagnosed as chronic idiopathic myocarditis. Because of the frequency of thromboembolic episodes anticoagulants may be indicated.

Summary

Six cases of chronic idiopathic myocarditis (cardiac hypertrophy) are described. The disorder is characterized by severe congestive heart failure, arrhythmias, markedly enlarged heart and sometimes pericarditis and thromboembolic episodes occurring in young to middle-aged adults. It carries a poor prognosis. Pathologically the hearts are big and flabby and show enlarged muscle fibers and diffuse interstitial fibrosis. No specific etiology has been determined and there is no specific treatment at this time.

Addendum: Since this report was written, an additional case that presents certain interesting features has been observed. The patient, a 54 year old white man, was examined and had a chest x-ray one month prior to his illness, at which time he was in good health. The heart was not enlarged and no murmurs were heard. Shortness of breath developed, a diastolic murmur of aortic regurgitation was heard, and the blood pressure was 190/40 mm. Hg. Thereafter, frequent pulmonary emboli, progressive cardiac enlargement and all the peripheral physical findings of aortic regurgitation developed. He died five months after onset with a mesenteric embolus. The electrocardiograms showed left ventricular hypertrophy. At autopsy, the heart weighed 700 Gm., and the aortic ring was dilated, but all valves were structurally normal.

There are two interesting features in this case. One is the hemodynamically significant aortic regurgitation which was due to dilatation of the arotic ring. The electrocardiograms showed almost pure diastolic overload of the left ventricle without any of the changes such as voltage that one might see with the myocarditis.

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References will be supplied by the author upon request.

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Certain Therapeutic Problems in a Patient With Habitual Abortion

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History

The patient was a tall, blonde, blue-eyed, attractive, childless, 38 year old married woman of Scotch-Irish extraction, whose chief complaint was depression and severe immobilization. Several months before coming for psychiatric treatment, she had visited a physician because of her inability to do things, which had been brought into sharp focus when her husband had completed arrangements to move to a new city for a much better position. She was completely in agreement that the proposed move was distinctly in their best interests, but simply could not bring herself to make the necessary arrangements. In addition, she felt uncomfortably self-critical, noticed that she was making too many sarcastic remarks, and began to isolate herself from friends. She was also considering adopting a child, since the endocrinologist who had treated her through her last three spontaneous abortions had finally committed himself that, on a somatic basis, she could never bear a child. Between the first and second visits to the psychiatrist, the patient and her husband were rejected by an adoption agency in an allegedly brusque manner. The existing symptoms were immediately exaggerated and, in addition, anorexia, profuse crying, and stomach complaints appeared. The referring physician was somewhat suspicious of a possible underlying schizophrenic factor.

She was seen twice weekly for the first six months, and then irregularly for the next three months. At the first interview she was gracious, friendly, and exceedingly cooperative. There was a controlled tearfulness as she related her problems and history:

She was an only child and a disappointment to her mother, who had hoped for years to use the name Darwin for a son. As a baby she ate poorly, was colicky, and had frequent illnesses, including nonparalytic polio. When she was three and one-half years old, she was operated on for intestinal obstruction, which she was told had been caused by eating too much candy. She recalled playing with her genitals during convalescence, and fearing that she would be caught. When she was five, her parents were divorced and her mother quickly married a much older man, whose poor attributes were exceeded only by those of her father's second choice. There was some shuttling back and forth before she finally stayed with her mother, "a small, narrow, incompetent woman who hit below the belt." Frequent moves introduced her to the school systems of six different states. At five she suffered from claustrophobia and school phobia, but subsequently she liked school and was a good student. It was always difficult for her to be one of the group. Enuresis stopped when she was 12 and migraine began at the same time. Orgastic self stimulation started at 13, accompanied by great guilt, and was subsequently infrequent. On dates she repelled all advances, and was a virgin when married at 21.

She was graduated from high school at 17 and was so shy that when answering an ad for a job she would walk around the block several times and then go home without approaching the prospective employer. She joined a local theater group and was encouraged to attend the American Academy in New York. Anxiety concerning her roles and increasing severity of migraine attacks finally discouraged this career. An influential friend secured her admission to a fashionable Eastern school, but she was unable to afford the fees. A brief period of work in a large department store terminated when she was discharged for telling off the supervisor after she was severely reprimanded for being late. Her first love affair ended painfully at about that same time, when her suitor suddenly married an heiress. She returned to the Midwest where she tried first her mother's and then her father's households and found them both impossible. She then moved in with a maternal aunt (who had at one time been hospitalized for a catatonic episode) and was more comfortable there than with either parent. Beginning work in a local department store, she quit after two months following an argument with the manager about insufficient heat.

At 21 she married her present husband. The first night of their honeymoon he fell asleep without touching her. For the next four or five months their sexual relations were poor because of her husband's inability to stay awake. There was some question of his having acquired a tropical illness, and matters gradually improved. Today

the patient feels that she is orgastic and there are no sexual complaints from either partner.

Immediately after the marriage, the couple moved to a Caribbean island where the husband worked. Here the patient's "illnesses" began. The first six episodes were between 1937 and 1941, and were identical in symptomatology. A low grade fever of short duration was followed by generalized aching converging toward the lumbar area. This was followed by extreme weakness, accompanied by marked hypersensitivity to smell, taste and hearing. She experienced abdominal pain, and "a feeling of bubbles of cold air rising in my esophagus, and popping sounds in my abdomen." The patient seemed to feel noise through the sensitive portion of her back. She was unable to read or concentrate and there was complete physical and mental exhaustion to the point where she could not lift a newspaper. Throughout these attacks, which all lasted six to eight weeks, she was terribly afraid she would die. (When asked at this point whether any physicians along the way had ever commented on the unusual nature of these symptoms, she answered, "I don't think they ever listened.")

The first attack ended in jaundice and hospitalization. The fourth attack was accompanied by severe cramps and ended in the passage of a firm, cylindrical mass which she thought at the time was "a worm coming out of the rectum," but which she now thinks must have been a miscarriage. During the fifth attack she was aware of a delayed period, and this and the next attack were diagnosed as spontaneous abortions. From 1941 to 1946, while her husband was in the service, there were no further episodes, but the migraine headaches became much worse. Several basal metabolism tests showed a reading around minus 30, and the patient began to take thyroid extract.

In 1946 the patient's husband returned from service and they moved to New York. In the following three years there were three more spontaneous abortions, with similar but milder symptomatology. In 1949 the patient again became pregnant and went to an endocrinologist. He gave her an Aschheim-Zondek test, which was positive, and administered stilbestrol and tocopherol. At the third month spontaneous abortion was followed by curettage. In January 1950 and again in December 1950 two more identical episodes occurred, each ending at the third month with spontaneous abortion and curettage. Subsequently she felt relatively well, worked at a nursery school, and did not become pregnant again although she took no precautions.

Some months before seeking treatment, the couple moved to the suburbs where they had purchased an old home. She developed a great love for this place, coupled with a remarkable inability to carry out her many ideas on renovating it. She planned, made notes, collected clippings, and so forth, but remained unable to do anything about it. This problem became crucial when it was necessary to liquidate the house in order to accompany her husband to his new position. After the rejection by the adoption agency, she moved into the acute depression and experienced the symptoms described.

Therapy

Since the husband had to leave in three months, the initial goal of therapy was to treat the depression and achieve sufficient symptomatic improvement to enable the patient to accompany him to the new city where further therapy might be arranged if necessary. She had apparently suffered considerable hard luck, with deprivation of warmth, affection and acceptance. The core of her problem appeared to be an almost unshakable conviction of worthlessness, with a strong unconscious suspicion that somehow all her misfortune was a logical outcome of her presumed stupidity and disobedience. At the same time there was an enormous accumulation of resentment toward the frustrating agents, to which the migraine, sarcastic remarks to friends, self-enforced isolation, and ever present nervous laugh bore witness. Because of the basic feeling of helplessness, an overevaluation of the strength of these frustrating agents resulted in an overreactive fear of retaliation for vengeful thoughts, and a concomitant shrinking overdependence. Acts of conscious nonresentful self assertion became equated with and mistaken for fantasied acts of unconscious resentful self assertion, leading to a "play it safe" immobilization. This constellation of fear, guilty fear, and repressed rage in this particular individual resulted in the clinical syndrome of depression and immobilization which unconsciously represented both her desperate, expiatory cry for help and the impounding of any activity which might in any way be interpreted as jeopardizing that help.

The plan of therapy, based on this formulation, was to answer the cry for help as loudly and promptly as possible, and then, in the atmosphere of revived hope, to attempt to correct the conception of helplessness and to allow the expression

of resentment in an atmosphere of complete approval. It was hoped that the patient could be taught that expression of rage was not as dangerous as she had come to believe, and that nonresentful self assertion was different from resentful self assertion.

The cry for help was answered loudly. The therapist was very active. Every effort was made to reinforce the patient's belief in her physician's superior powers, and to convince her of his sincere desire to help. Medications were given freely, psychophysiological explanations were made with authority; the therapist was frequently early for appointments and never late, his home telephone number was given to the patient, and she was encouraged to call him at any time. On a suddenly rainy and windy day she was called by the therapist and advised not to drive to the city for her hour. Silences during visits were quickly broken by the therapist as he consciously attempted to keep his general attitude at a high pitch of enthusiasm and interest. Any available realistic basis was utilized to bolster the patient's confidence. An unexpected bonus in this campaign materialized in the early weeks of treatment when a carpenter, who was making some repairs in her home, suddenly threw his arms around her, and then apologized profusely, blaming his action on her irresistibility.

After about two weeks, the depression began to lift. The patient's despair seemed to be giving way to trust and confidence. She felt more free to criticize her mother and husband, and also began to express her violent dislike of a neighbor, a woman who, she felt certain, was out to harm her socially. There was a definite paranoid flavor in this last incident which later subsided.

A month after therapy began, she announced that her menses were delayed and the symptoms of her former pregnancies had already begun: nausea, hypersensitivity to sound and odors, abdominal pain, weakness, and easy fatigability. Her depression returned. Dexamyl was prescribed, along with injections of pyridoxine hydrochloride (vitamin B_6) for the nausea. Following this treatment the symptoms vanished and the patient was encouraged to see her endocrinologist. She did so, and there immediately developed a situation which, in retrospect, is believed to have been a crucial one psychodynamically. The endocrinologist forbade her to take the Dexamyl and vitamin B_6, allowing only the progesterone which he had recommended. Two days later she called the therapist, telling him what had happened and saying that she felt bad again, and asking him what to do. She was advised to take the Dexamyl and call back if not relieved. At the next session she told of being relieved by the drug in about half an hour. The remainder of the session was spent mocking the endocrinologist's authoritative attitude and his emphasis upon progesterone as the sole panacea this time, whereas in the last miscarriage he had championed stilbestrol just as vigorously.

When the therapist offered to get in touch with the endocrinologist for the purpose of ascertaining his reason for forbidding the medication, the patient said she would rather ask him herself. She did, and in the next session reported that he had back-tracked and told her she could use Dexamyl if she felt absolutely miserable and that she could take the "B_{12}," too. She did not pick him up on this slip, but reported it to the therapist as evidence of the endocrinologist's lack of sincerity. She nevertheless continued to see the endocrinologist and to take progesterone. Soon she developed a dislike and distrust of her obstetrician and changed to another one, of whom she was very critical for the remainder of her pregnancy, observing at one time that "he doesn't seem to like women and children."

In the months that followed, she would almost joyfully bring to the therapist any incident which might show up the endocrinologist or obstetrician as not really being 100 per cent interested in her welfare. One talked mostly about his hobbies and family; the other talked of cesarean section when she knew her pelvic measurements were normal; and again the other would hold up a vaginal slide and make comments such as "Well, it isn't the best I've seen, but it isn't the worst." She was obviously frightened by these remarks but gave vent to her feelings by criticizing the tactlessness of the speakers. It was possible to show the patient a temporal relation between some of these remarks and mild bouts of symptoms. In the fifth month she asked her obstetrician about intercourse and he forbade it. She then asked the therapist's opinion and was told that it was perfectly all right for physically normal women, and he was quite convinced that she was that kind of woman. She had intercourse with no untoward results.

One wonders whether this continuous critical commentary on her endocrinologist and obstetrician to her psychiatrist was duplicated by similar

commentary on her psychiatrist to her obstetrician and endocrinologist. In any event, a unique opportunity was offered for the continuous expression of resentment in an atmosphere of complete approval. In addition to affording a safety valve for tremendous hostility, the patient was able to kill the authority of the authority and preserve the protection of the authority—a neat trick if one can do it. These dynamics were not pointed out to the patient. Their fire may have been fanned somewhat by the therapist.

The husband was seen once again by the original referring psychiatrist and came away from the interview with a much more genuine appreciation of both the patient's and his own problems, planning to start therapy himself at a later date. This reaction was most helpful to the patient. As the house was not yet sold, the husband left for the new job alone, his wife planning to join him as soon as the sale was completed. She began to do more and more, eventually working with great enthusiasm and enjoyment, painting, planning, and directing the workmen. The house was finally sold at a tidy profit, the implication being that her efficiency and talent for decorating were largely responsible. Since her husband had not yet found adequate quarters in the new location and her confinement was imminent, the patient stayed in Florida at the apartment of a friend. There was one more mild bout of symptoms, following directly after a remark of her obstetrician, "I'm certainly surprised at the normalcy of everything in the face of your terrible OB record."

In the eighth month of her pregnancy, the therapist was no longer able to see the patient, but she was encouraged to telephone to him, and did so regularly, at least once a week. At term, in an easy labor, the patient delivered a normal 8½ pound boy. She was seen once in the hospital where she was a very happy woman.

Summary

This patient, after three documented spontaneous abortions and nine additional probable ones, gave birth to her first child at the age of 39. Exactly concurrent with this first normal pregnancy was her first psychotherapeutic experience. The possibility that there is more than a temporal relation between these two experiences is a good one.

There is considerable experimental and anatomic evidence that emotions may activate the uterine musculature to contract and thus cause placental separation. Radiologic study has demonstrated irritable uteri in habitual aborters. Domesticated animals abort more frequently in unfavorable or wild environments. Reports from a number of psychiatric workers indicate favorable results following psychotherapy. There is also a large body of informal data on the role of emotion in abortions seen in patients exposed to shock, fright, or dangerous episodes. Although hormonal therapies have been given extensive trial and the rationale behind the use of progesterone seems logical, clinical studies based on the use of these agents have at least as many opponents as supporters. There is no reason why the inner circular muscle layer of the uterus, which acts as a sphincter, cannot be stimulated to contraction by fear through the autonomic nervous system, exactly as occurs in the bladder and the intestine. Chronic spasm of this muscle layer, as well as of the blood vessels themselves, can interrupt the blood supply running through the myometrium to the endometrium, resulting in ischemia, bleeding and placental separation. The decrease in progesterone elaborated by the placenta may very well be the result of this, rather than the cause, as pointed out by Kroger and Freed.[3]

For whatever reason the uterus becomes the target of the emotional bombardment; each repeated failure in an habitual aborter increases the fear and results in a cumulatively better chance of difficulty. In this patient, all of her fears became focused on pregnancy, and bearing a child came to mean much more than just bearing a child. The repeated miscarriages, the final opinion of irreversible somatic defect given by the endocrinologist, the official rejection by the adoption agency, and the painful, teasing effect of nursery work with children all contributed some understanding to this psychological focusing.

Although one can guess what the reasons for repudiation of the maternal role may have been, one does not have to guess about the associated feelings; they were fear and rage. It is thought that this knowledge alone, if properly implemented, can be a reliable tool in the hands of most physicians.

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Management of the Thyrocardiac Patient

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Burwell and Eppinger[1] defined a thyrocardiac patient as one in whom angina, congestive heart failure, or arrhythmias, usually auricular fibrillation, occur in association with hyperthyroidism. Whether or not the increase in thyroid function is the sole cause of these symptoms is academic. Thyrocardiac disease should be suspected in the presence of paroxysmal auricular fibrillation, unexplained tachycardia persisting during sleep or when a patient is under sedation, in cardiac disease of unknown origin, in intractable angina and in congestive heart failure not responding well to conventional therapy.[3] In the older age groups the clinical manifestations of hyperthyroidism may no longer be present or obvious, particularly if the disease has existed and has been slowly progressive or is smoldering over a long period of time; then only the cardiac symptoms may be present.[2] Advancing age in underlying heart disease will accelerate and aggravate cardiac symptoms in the hyperthyroid patient, and neglect in the treatment of hyperthyroidism can result in irreversible cardiac damage.[10] The disease is often difficult to diagnose, and yet thyrocardiac patients are salvagable. Frequently the values in the radioactive iodine uptake study and protein-bound iodine study are in the upper limits of normal or just above them. A high degree of suspicion is necessary to make the diagnosis of thyrotoxicosis with associated cardiac manifestations.[2]

Hyperthyroidism can produce heart disease more often and to a greater degree in hearts already damaged by other processes.[5] In Burwell's series[1] 25 per cent of the thyrocardiac patients failed to have any other organic heart disease. Summers and Surtees[6] reported that in their group of cases 50 per cent of the patients having thyrotoxicosis associated with heart disease had either rheumatic heart disease, arteriosclerotic heart disease or hypertensive heart disease, and in the remaining 50 per cent they could find no other cause than the thyroid as an etiologic agent. They reported that in these patients cardiac disease usually occurred in association with a nodular goiter, at an average age of over 50. Engstrom and his group[7] thought that if auricular fibrillation is present with a nodular goiter, the odds are two to one that the goiter is toxic.

Griswold and Keating[8] reported an incidence of 14 per cent of thyrocardiac patients in their group of patients with thyrotoxicosis. Seventy-five per cent had auricular fibrillation; in 40 per cent of this number nodular goiter was present, and in 60 per cent the auricular fibrillation was associated with toxic diffuse thyroid disease. Of all the thyrocardiac patients with toxic nodular goiter, about 70 per cent had auricular fibrillation. Eller and Silver[9] reported that 14 per cent of their patients had auricular fibrillation and 2 per cent paroxysmal tachycardia, and in their series auricular fibrillation was more common in patients with toxic nodular goiter than in those with toxic diffuse thyroid disease.

In my series, consisting of 100 cases of thyrotoxicosis in which the patients were treated with radioactive iodine, 35 per cent were thyrocardiac patients. Of this group with thyrocardiac disease, 43 per cent had congestive heart failure, 45 per cent had auricular fibrillation, 23 per cent had angina, one had Adams-Stokes syndrome, several had hypertension and several had paroxysmal tachycardia. Associated cardiac diseases in this series consisted of arteriosclerotic heart disease, rheumatic heart disease, and hypertensive heart disease.

Rasmussen[11] in 1941 suggested that there was a specific cardiotoxic effect of the thyroid hormone. More recently[12,13] a thyrotropic agent has been identified in the serum (a long-acting thyroid stimulator). A thyrotropin-releasing substance has been found in the hypothalamus. The secretion of this substance is inhibited by thyroid hormone. In addition, an adrenohypophyseal thyrotropin has been found as has an exophthalmos-producing substance. The physiological actions of the adrenomedullary hormones may be related to certain aspects of thyroid function. Metabolic and pressure effects of epinephrine are potentiated or depressed by thyroxin (directly proportional) and the myocardium is thereby sensitized. Thyrocardiac findings of tachycardia, auricular fibrillation, and anoxic electrocardiographic changes may represent thyroid-potentiating effects of epinephrine. In turn, the adrenal medulla potentiates thyroid function. The cardiac output is geared to the metabolic demand which may exceed the ability of the aged or damaged myocardium or arteriosclerotic coronary tree. Diminished

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cardiac reserve may handle lowered requirements of the decreased or euthyroid metabolic states and constitutes the basis for converting the hyperthyroid to the euthyroid or hypothyroid state.[14]

Clinical Manifestations

On examining a patient with pronounced thyrotoxicosis, evidence of involvement of the cardiovascular system is usually obvious. In the neck there are active pulsations in the carotid artery. The pulse is rapid, full and bounding. The apex impulse is rapid and forceful and the heart may be enlarged to percussion. The heart sounds are overactive, the first sound being loud and abrupt. There may be an apical systolic murmur, and at the base not infrequently a systolic murmur is heard over the second and third left interspaces which may have a suggestive rubbing quality. This is increased in intensity by pressure with the bell of the stethoscope. This murmur may be related to dilatation of the pulmonary conus which frequently is seen in fluoroscopic and x-ray examinations of these patients. An increase in pulse pressure is noted, accounting for the bounding pulse and visible increase in the systolic excursion of the carotid arteries while maintaining a normal mean pressure. Occasionally pulsations of the liver and spleen have been observed.

These are the signs of an overactive heart.[1,15] The presence of small areas of ischemia in the muscle of the auricle secondary to coronary vascular disease can induce fibrillation in a heart that is overactive as the result of thyrotoxicosis. The cutaneous vasodilatation decreases the peripheral resistance in the vascular system. The heart then responds with a sufficient increase in rate to maintain a normal blood pressure within the aorta. This entails an increased volume of cardiac output per minute, increased rate of work by the heart and ultimate embarrassment of the myocardium. In thyrotoxicosis the blood volume is increased, the cardiac output decreased, the blood flow accelerated, and the skin capillaries dilated. The thyroid hormone's action on cellular metabolism may be such that it uncouples oxidative phosphorylation, leading to inefficient oxygen consumption and impaired use of energy sources important for contractile processes. It is postulated that some such metabolic defect in the myocardium may contribute significantly to the development of heart failure when it occurs in thyrotoxicosis.[15]

A clinical study of thyroid storm enhances the knowledge of the basic nature of thyrocardiac disease for this storm state represents the augmented life-endangering symptoms of thyrotoxicosis among which cardiovascular signs are prominent. In Wallstein's study[16] the incidence of thyroid storm in patients hospitalized for hyperthyroidism was 7 per cent. Paroxysmal tachycardia, increased pulse pressure, congestive heart failure and arrhythmias were common. Diastolic hypertension occurred in 15 per cent of the patients and in one patient it was present only during storm. Cardiomegaly and nonspecific apical systolic murmurs were frequent. In those cases that were fatal, by the time therapy for storm was begun congestive heart failure, digitalis intoxication, and jaundice were significant complications. Post storm patients seemed to retain the propensity for this complication until hyperthyroidism had been controlled for a considerable period. Surgery in these patients induced another storm episode, whereas radioactive iodine therapy was tolerated well and did not, as a rule, precipitate storm. Thyroid storm may be referred to as decompensated thyrotoxicosis implying exhaustion of the tolerance of the body to excess hormone.[16]

As mentioned previously, the usual diagnostic tests (basal metabolic rate, protein-bound iodine, and uptake studies) may be misleading[17] for a hyperfunctioning adenoma may suppress the function of the remainder of the thyroid so that these tests may be normal or in the upper limits of normal. With a high degree of suspicion[9] and the use of the thyroid scan[18] a "hot" adenoma (one having a high avidity for iodine) may be demonstrated. Extirpation of such a "hot" nodule either surgically or with the use of radioactive iodine will be rewarding. Early recognition and successful therapy of thyrotoxicosis should theoretically prevent the cardiac complications from emerging.[23]

Therapy

Iodides are used only if the patient refuses radioactive iodine therapy or if a contraindication for such therapy exists, such as adolescence or pregnancy. They are used then only 10 days to two weeks preoperatively to prepare the patient for operation. The other indication for the use of iodides is in the emergency thyroid storm state (crises). Here their action is solely confined to blocking the release of thyroxin into the blood stream. The specific therapy in this state consists of steroids and reserpine or guanethidine (Ismelin).[16] If iodides are used promiscuously, they tend to negate the effect of subsequent radioactive iodine therapy by blocking the uptake of the radioactive iodine.

Silver[19] stated that antithyroid drugs are usually unsatisfactory in treating thyrocardiac patients. He suggested, however, giving antithyroid drugs for several months before treatment with radioactive iodine in the more severe cases, particularly in the aged with associated heart disease, in order to effect a depletion in the gland of stored hormone. He recommended discontinuation of the antithyroid drug two to five days prior to giving the specific therapy of radioactive iodine. He thought that hyperthyroidism in the aged cardiac patient is a prime indication for radioactive iodine therapy since the surgical risk is significantly increased in such patients and he further cautioned about the use of large initial doses. In the literature[9,10,14,19,22,23,24] the dose of radioactive iodine varies from 6 to 20 millicuries, the average being 12 as contrasted to that used in thyrotoxicosis with heart disease where the dose varies from 2 to 12 millicuries, the average being 4 to 6 millicuries. In my series of cases the dose varied from 4 to 12 millicuries. In anginal cases the patient frequently required more than one dose.

In my series 36 thyrocardiac patients were treated with radioactive iodine. Two were in their thirties, six in their forties, 11 in their fifties, 11 in their sixties, and six in their seventies. As a rule patients with thyrocardiac disease, particularly those with congestive heart failure, rapid auricular fibrillation, and supraventricular tachycardia with rates of 120 or over, and those with angina, are hospitalized. Digitalization, if indicated, is induced, for contrary to a former belief, digitalis may have a slowing effect on the thyrotoxic heart. Hydration is maintained, a high caloric diet is prescribed, and fever is treated with aspirin. Infection is avoided and if it occurs, antibiotics are given. Antithyroid drugs are given in the more severe cases until two days to one week prior to therapy with radioactive iodine. Sedation is attained with phenobarbital rather than with tranquilizers. Rauwolfia compounds, such as reserpine, act by decreasing the secretion of thyroid-stimulating hormone, exerting an exact antithyroid effect, and inhibiting norepinephrine through the central nervous system.[20]

The clinical effects are produced without significant changes in the protein-bound iodine or thyroidal uptakes of radioactive iodine, used in doses of 8 to 10 mg. daily. Alseroxylon (Rauwiloid) has produced variable but sometimes striking relief, even reverting atrial fibrillation to normal rhythm, narrowing the pulse pressure and decreasing dyspnea. Basal metabolic rates may decline rapidly on occasion. The beneficial effects of Rauwolfia alkaloids, when used over a long period, may diminish; therefore they should not be used except as adjunctive therapy together with antithyroid drugs or I_{131} to bring about symptomatic improvement during the latent response to more definitive measures. One should not use such agents for several weeks before an operation is contemplated because of the severe hypotensive episodes resulting from the administration of anesthetics in patients receiving this drug. Intramuscular reserpine has proved more effective than oral therapy and is useful in the treatment of patients with extremely severe cases of thyroid crises.[20] More recently Lee and his coworkers[21] have used guanethidine in an oral dose of 80 mg. daily. This compound acts at the nerve arterial junction where it apparently opposes the release and/or distribution of the pressor substance, norepinephrine. Within a period of two to 14 days all thyrotoxic symptoms are relieved including palpitation. After the symptoms and signs are brought under control, the patient is given specific therapy of radioactive iodine orally. In my series only four of the 36 patients required more than one dose of radioactive iodine. Two required two doses and two required three doses to achieve a satisfactory result.

Delit[10] reported improvement in his series in 86 per cent of the thyrocardiac patients above the age of 50 who were treated with radioactive iodine, as compared to 96 per cent of the total number of cardiac patients. Ninety-two per cent of his patients with congestive heart failure secondary to thyrotoxicosis were improved, as compared to 82 per cent over the age of 50. One hundred per cent of his patients with angina under age 50 were improved, as compared to 90 per cent over 50. Eighty-eight per cent of his patients were over 50 years of age. Three thyrocardiac patients (1.2 per cent) had a recurrence, but there were no recurrences among patients with fibrillation only. Normal rhythm, when obtained, was usually obtained within four to nine weeks. In the series reported by Summers and Surtees[6] the prognosis was good in cases where true thyrocardiac disease existed and was relatively poor comparatively in cases where thyrotoxicosis was associated with organic heart disease. When a normal sinus rhythm was not established after treatment, it was usually obtained with quinidine. They reported that the heart size did not change

following treatment if cardiomegaly existed prior to therapy. Richard and his group[22] reported that the thyrocardiac patients required significantly larger doses of radioactive iodine for control of hyperthyroidism than did the patients with classic Graves' disease without severe cardiac involvement.

In my series the results were approximately the same as those reported in the literature. One death associated with the therapy occurred in an elderly woman with auricular fibrillation and congestive heart failure prior to treatment. Following therapy auricular fibrillation was converted to a regular rhythm, but a thromboembolism developed in the leg two weeks after therapy. The patient was operated on for this condition and died postoperatively. This death occurred prior to the use of Rauwolfia compounds or guanethidine and has led me to recommend that patients with fibrillation be given quinidine prior to, during and after treatment and on some occasions I have recommended the use of anticoagulants. Three other deaths have occurred among this group of patients since therapy. One occurred one year after treatment in a patient having arteriosclerotic heart disease associated with diabetes. Another patient died following a cerebrovascular accident three years after treatment; hypertension was present prior to therapy. A third patient had a fatal heart attack five years after treatment; she gave a history of having had a heart attack three years prior to treatment and she also had angina prior to treatment.

Conclusion

The elusive diagnosis of thyrotoxic heart disease is obviously worth pursuing. A high degree of suspicion in patients with intractable angina, paroxysmal and supraventricular tachycardia, auricular fibrillation, and congestive heart failure will lead to the proper therapy for a condition which, if untreated, results in a high degree of morbidity and inevitable mortality. The excellent results obtained with radioactive iodine in the treatment of the thyrocardiac patient compare favorably with the most successful treatment of any condition as potentially dangerous as this. A series of 100 cases of thyrotoxicosis is reported in 35 per cent of which thyrocardiac disease was present.

References will be supplied by the author upon request.

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Choice of Digitalis Preparations for Adults, Children and Infants

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Without historical survey and without preliminary discussion of the pharmacologic effects of digitalis, this review is presented to give an opinion in regard to which digitalis preparation or preparations are advantageous for the treatment of congestive heart failure, the control of the ventricular rate in atrial fibrillation, and the abolishment and prophylaxis of various types of paroxysmal rapid heart action.

Whole Powdered Leaf of Digitalis Purpurea

Tablets of the whole powdered leaf may be used for the routine digitalization and control of most patients with congestive failure and atrial fibrillation. It has been shown that in the untreated patient with atrial fibrillation and a rapid ventricular rate, enough of the powdered digitalis leaf may be given by mouth within a 24 hour period to slow the ventricular rate to 70 beats per minute approximately, that the average amount required for this effect is 1.8 Gm. and that this amount is essentially the same regardless of the age and body weight of the patient except in infants and very young children. While Stewart[1] found that the average maintenance dose of the whole leaf in such patients is 0.2 Gm. daily, it is our experience that the requirement is between 0.1 and 0.2 Gm. daily. Even smaller daily rations, perhaps 0.05 Gm., are useful for its vagal effect in the prophylaxis of supraventricular tachycardias. Toxic effects are rarely produced by the whole leaf when digitalization and the maintenance dosage are intelligently observed and controlled. In our experience it is a rare patient indeed in whom the disease cannot be adequately

controlled with the powdered leaf without the development of toxic symptoms.

The powdered leaf can be used if the patient is not troubled with nausea and vomiting from any cause including digitalis poisoning itself and if there is no need for a more rapidly acting preparation which may be given intravenously. It has been shown by Batterman and DeGraff[2] that if the desired effect is not being maintained satisfactorily on digitalis leaf and toxicity occurs with an increase in dosage, the substitution of a digitalis leaf glycoside such as digitoxin will result in toxicity, if comparable doses are used.

Digitoxin

Digitoxin is a glycoside which is derived from Digitalis purpurea and can be obtained from the hydrolysis of lanatoside A. Although it can be prepared in pure form, it has been shown by Dick[3] that the potency of various digitoxin preparations varies considerably. While Gold[4] advocated a digitalizing dose of 1.2 mg., this has been found not to be enough in most patients and it appears that the amount required is comparable to the amount of whole leaf, namely, approximately 1.8 mg. orally. The average maintenance dose of digitoxin is less than 0.2 mg. in our experience, and is approximately 0.1 mg. with 0.2 mg. on alternate days, or 0.15 mg. daily. In some patients the effect desired may be well maintained on 0.1 mg. daily while others may require more than 0.2 mg. daily.

Although digitoxin can be given intravenously, it is rapidly absorbed and utilized when given by mouth in the same dosage. Those solutions of digitoxin which contain alcohol may cause pain when given intramuscularly; otherwise the intramuscular route allows almost as rapid absorption and action as by vein. One cubic centimeter of the intravenous solution contains 0.2 mg. of digitoxin. One advantage of digitoxin is that since it is suitable for intravenous use and since the intravenous dosage is practically identical with the oral dosage, the route of administration can be changed in patients who are nauseated or who are vomiting, or in other patients in whom the oral administration is not suitable.

It should be emphasized, however, that when this drug is given orally, there is no marked advantage in speed of digitalization when compared with the whole powdered leaf given by mouth in comparable doses of potency, since 1.0 gm. of leaf is approximately equal to 1.0 mg. of digitoxin. Indeed, when rapid digitalization is attempted by digitoxin, it is our experience that nausea and vomiting occur as frequently as in the case of the whole leaf. Furthermore, we find it as easy to maintain the desired effect on stable rations of whole leaf as with digitoxin. It is our experience also that early toxic signs from the maintenance use of whole leaf usually include anorexia and nausea whereas more serious toxic signs in the case of digitoxin frequently develop without the warning loss of appetite and nausea. We refer to multiple ectopic ventricular beats and ventricular tachycardia. Stewart[1] stated that he has seen atrial paroxysmal tachycardia with two to one atrioventricular block or complete atrioventricular dissociation, which we also have observed, occur so frequently following its use that he restricts the occasions on which digitoxin is given. Furthermore, when toxicity occurs from digitoxin, it may be of relatively long duration since the drug is excreted slowly. The toxicity due to the whole leaf may disappear if a smaller dose is given whereas when toxicity occurs from digitoxin, the drug should be discontinued.

Digoxin

Digoxin is a pure glycoside obtained from Digitalis lanata leaf from the lanatoside C fraction. The advantage of oral digoxin is its rapid absorption and utilization which are maximal in three to four hours. It has been shown to increase the cardiac output within 20 minutes after the intravenous injection; furthermore, it is excreted in 36 hours, which means that any toxicity from its use is of short duration. Its intravenous use is practical for rapid digitalization in approximately 1.5 mg. amount. It has been found that the average oral digitalizing amount in a 24 hour period is approximately 3.75 mg. and that the average maintenance dose is between 0.5 mg. and 0.75 mg. daily. We have patients with chronic and established atrial fibrillation whose maintenance dose is 0.25 mg. of digoxin daily. This preparation is a useful one which seems to have become popular in recent years.

Lanatoside C

Lanatoside C is another crystalline glycoside obtained from Digitalis lanata leaf and its definite advantage is an extremely short latent period when given intravenously. Its effect on cardiac output has been reported as evident in one-half to one hour after injection and is maximal in one to two hours after injection. It is rapidly excreted, within 72 hours or so. It has achieved prominence because of reports of its use in the

treatment of supraventricular paroxysmal tachycardia, atrial flutter and acute heart failure. It is doubtful, in our opinion, that lanatoside C is specifically useful for these purposes other than for its rapid utilization. It has been shown that the range between therapeutic and toxic dose is variable and is small in some patients; therefore, it has not become widely used for routine oral use nor for maintenance. Its oral use is not recommended.

Gitalin

Gitalin is amorphous, is a mixture of glycosides rather than a specific glycoside and is obtained from the aqueous extract of Digitalis purpurea. It is said to be more uniform in its potency from batch to batch than some of the glycosides. Its latent period is between that of digitalis and digitoxin and it is not dissipated as rapidly as digoxin or lanatoside C, but more rapidly than digitoxin or digitalis leaf. It is used orally and its average 24 hour digitalizing dose is reported by Batterman and DeGraff[2] as 5.7 mg. The daily maintenance dose varies from 0.25 to 1.25 mg. Five milligrams of gitalin is approximately equivalent to 0.1 Gm. of digitalis leaf in terms of potency. The big advantage claimed for gitalin is that its therapeutic dose is approximately 38 per cent of the toxic dose.

Strophanthin (Ouabain)

Mention should be made of ouabain, a very rapidly acting pure crystalline glycoside which is used intravenously since it is not adequately absorbed by the oral route. It has a very brief latent period and is excreted within 24 hours.

Acteyl Strophanthidin

Acteyl strophanthidin is very rapidly effective and is rapidly excreted but has not been sufficiently studied in clinical practice yet. A digitalis-like substance, it is a synthetic ester of the cardiac aglycone, strophanthidin, has the most rapid onset of action after intravenous administration and is more rapidly dissipated than any other of the digitalis preparations. It has been used as a test to determine the degree of digitalis effect in patients whose digitalis status is in doubt.[5]

The technique is described by Lown, Crocker and Levine[5] follows:

"Two cc. of acetyl strophanthidin (1.1 mg. or 6 cat units) is diluted to 20 cc. in 5% glucose and water. If the patient to be tested has received little or no digitalis, 5 cc. of the dilution of acetyl strophanthidin (1.7 cat units or 0.27 mg. of the dilution) is given intravenously every 5 minutes until either a therapeutic effect or a mild toxic response is noted. If the patient has had previous digitalis, the initial dose is reduced by one-half. If the patient is critically ill, a 10 minute interval is to be preferred. The electrocardiogram is observed repeatedly for evidence of augmented ventricular irritability or alteration in the atrial complex as recognized by the acceleration of the atrial rate, prolongation of A-V conduction and changes in the contour of the P wave. If atrial fibrillation is the underlying rhythm, acceleration and regularization of the ventricular response are regarded as evidence of toxicity. On observation of either atrial or ventricular manifestations of toxicity, drug administration is discontinued. Procaine amide is given intravenously immediately in a dose of 50 mg. every two minutes. If toxicity is not promptly controlled, potassium is administered, in dosage of 40 mEq. in 500 cc. of distilled water, intravenously in 60 to 90 minutes."

Squill

The active principle of squill has a digitalis-like effect, but appears to have no advantages over digitalis. The characteristics of the squill preparations are summarized in the accompanying table. No doubt any one of these preparations is entirely suitable for routine use. Generally speaking, for reasons earlier mentioned the powdered leaf preparation is entirely satisfactory as are digoxin and any of the other preparations the effects of which have become familiar to the physician by routine use.

Acetyl Digitoxin (Acylanid)

This drug is the newest of the purified glycosides obtained from Digitalis lanata and is said to be well absorbed from the alimentary tract. Sufficient experience with this preparation has not been accumulated as yet to justify comparison with the older and well established preparations.

Clinical Applications

The clinical applications of any digitalis preparation are dependent upon the physiologic effect. While therapeutic doses of the various preparations have been shown to increase the force of the contractions of the cardiac muscle, it has also been demonstrated that they similarly affect the contractions of the skeletal, arterial and venous smooth muscle. This effect does not increase the cardiac output of the normal heart. A basal constrictive effect has been demonstrated in the peripheral veins and in the hepatic smooth muscle.[6,7] In the failing myocardium, however, the increased force of contraction leads to increased car-

diac output, and a reduction in the size of the failing heart with a resulting increase in efficiency in respect to oxygen consumption has been observed.[8-10] Conduction in the atrioventricular node is depressed, the degree depending upon the dose used.[11] Because the refractory period of cardiac muscle is reduced, its irritability is increased and may give rise to ectopic ventricular beats.[12]

Although direct effect on the cardiac pacemaker, the sinus node, is not demonstrated, an altered vagal activity produces enhancement of vagal stimuli on the sinoatrial node, as well as on the atrial musculature. No direct diuretic action occurs, but the improved circulation and increased renal blood flow may augment glomerular filtration and lead to an indirect diuresis. A direct renal action on the tubules with increased salt and water elimination, dependent upon some depression of reabsorption of the glomerular filtrate, has been demonstrated.[13]

No significant alteration of the arterial blood pressure levels occurs although both arterial and venous vasoconstriction may occur. The elevated venous pressure secondary to myocardial failure may be reduced because of the increased cardiac output secondary to the increased strength of contraction in the failing heart.[14] The ideal indication for digitalis therapy is myocardial failure in which the increased cardiac output afforded by the digitalis preparation is of considerable value.

The rapid ventricular rates, the pulse deficit and the evidence of failure seen with atrial fibrillation are markedly improved by the depression of conduction which leads to a slower ventricular rate, a greater ventricular filling and an increased cardiac output. Occasionally atrial flutter is converted to atrial fibrillation by digitalis and the rate thereafter slowed to satisfactory levels. In such an event after withdrawal of the digitalis the atrial fibrillation occasionally reverts to a normal sinus rhythm. In some instances an increase in the atrioventricular block reduces the ventricular rate to a satisfactory level even though the flutter persists. Paroxysmal atrial tachycardia often responds to digitalis therapy by reversion to normal mechanism. It is thought that the digitalis alters the vagal activity so that vagal stimuli are more effective, such as carotid sinus stimulation, in bringing about cessation of attacks. Some evidence indicates that the combination of digitalis and quinidine is more successful in the conversion of atrial flutter and atrial fibrillation than is either digitalis or quinidine used singly. Although ectopic beats, especially those which are ventricular in origin, may be an early sign of digitalis toxicity, both atrial and ventricular beats not due to digitalis are frequently controlled by digitalization, especially the type seen in disease of the left ventricle.

Many clinicians believe that patients with severe hypertension without definite signs of myocardial failure, but who may have increased circulation time, are benefited by digitalization, and that the onset of congestive failure is retarded thereby. Although digitalis is usually withheld from the patient with an acute myocardial infarction because of the fear of producing an easily induced irritability with the danger of ventricular tachycardia, yet if congestive failure develops in such patients, digitalization is indicated and may be lifesaving, but should not be given intravenously as a rule. When there is a complete heart block with congestive failure, digitalis is indicated and may even be used in incomplete heart block with congestive failure, provided, of course, neither of the conditions mentioned has been induced by the drug.

In the absence of congestive failure digitalis is of little or no value in the relief of the symptoms of bronchiectasis, emphysema, pneumonia and asthma. The tachycardia of hyperthyroidism is not appreciably reduced by digitalis even in the presence of congestive failure until the thyrotoxic state is controlled. In the absence of congestive failure congenital heart lesions per se are not benefited, nor are mechanical states such as constrictive adhesive pericarditis. The peripheral edema of renal and hepatic disease does not respond to digitalis.[14]

Toxicity

The digitalis preparations must be given in adequate amounts to produce the therapeutic effect or some evidence that an adequate dosage has been used. The absorption and utilization as well as the excretion of these preparations vary from individual to individual, and the dosage must be tailored to the individual patient. It would be ideal to be able to utilize the minimal amount of digitalis which will produce the maximum desired therapeutic effect, but sometimes the therapeutic effect is not observed even after early evidences of toxicity appear. Although patients often state that they cannot take digitalis because they are sensitive or allergic to it, actual true allergy is

extremely uncommon although it has been demonstrated.[15]

The most commonly recognized toxic effects of digitalis are anorexia, nausea and vomiting; these are occasionally accompanied by diarrhea. Usually the anorexia occurs before other symptoms, but paresthesias are not uncommon early symptoms. Sometimes increased salivation and occasionally abdominal cramping pains occur. The vomiting center in the brain is stimulated by the digitalis and there is minimal, if any, nausea or actual vomiting due to local gastrointestinal irritation. The commonly used antiemetic drugs, the phenothiazines, are of less value in the nausea and vomiting due to digitalis than they are in other forms of emesia.

The toxic evidences of digitalis effect on the central nervous system include most commonly some disturbance of vision which frequently results in dimness and eventual coloration of the vision so that things appear to be more or less blurred, or yellow or some other color than actual, with or without some sensation of "spots before the eyes." Vertigo is such a common symptom in elderly people that it is hazardous to attribute it to digitalis, but no doubt it is sometimes a contributing factor. Headache due to digitalis is uncommon, but does occur. More commonly, however, malaise, reported as "feeling weak," is experienced. Rarely, a psychotic state is induced by digitalis, and a trigeminal neuralgia has been reported as a result of digitalis toxicity.

When a loss of potassium is induced or aggravated by thiazide diuretics, toxic doses of digitalis may aggravate electrolyte imbalance, sometimes with disturbance of the renal function producing an increase rather than diminution of edema fluid. The most serious evidences of digitalis toxicity are the tachycardias and arrhythmias which often are first evidenced by premature beats, both atrial and ventricular in origin, as well as production of first and second degree heart block. Among these arrhythmias are paroxysmal atrial tachycardia[16, 17] with or without some degree of block, nodal tachycardia, ventricular tachycardia, complete heart block and even the onset of terminal ventricular fibrillation.[14]

When a patient with myocardial failure responds well to digitalis with a satisfactory slowing of the heart rate, but, without change in the daily ration of the drug, shows increasing failure with an increasing heart rate or with bouts of definite arrhythmia, this response is usually evidence that toxicity is occurring and that the daily maintenance dose is too great.[14] Factors which seem to render patients less well able to tolerate the usual dosages of digitalis appear to be age, that is to say the elderly arteriosclerotic patient, the state of acute myocardial infarction, any state in which there is a definite electrolyte disturbance including chronic pulmonary disease and renal failure, and for some reason not too well understood cerebral vascular accidents including those due to hemorrhage and thrombosis.[14]

Occasionally there is induction of evidence of digitalis toxicity by the administration of calcium because of a definite synergistic action between digitalis and the calcium ion.[18] For this reason it is advisable to avoid calcium therapy in any amount in a patient who is receiving digitalis. The calcium gluconate in small dosage which is used in determining the arm to tongue circulation time, however, is not hazardous in this respect.

The matter of the synergy between calcium and digitalis has been studied with convincing evidence that digitalis produces an increased accumulation of calcium in the heart, but it does not do so to such an extent if the potassium concentration is at the same time elevated.[19] It has been well documented that digitalis in therapeutic as well as in toxic doses leads to loss of potassium from the heart.[23] It is axiomatic that the treatment of toxicity should include the omission of digitalis and drugs which might further deplete intracellular potassium and disturb the calcium-potassium-electrolyte balance. Such drugs include the thiazides, mercurial diuretics and corticoids.

When a patient is not seriously ill from the digitalis toxicity and when the evidences of the toxic state do not rapidly disappear as a result of cessation of the drug, the administration of potassium chloride by mouth in comparatively small dosage, usually 5.0 Gm. twice daily for 24 to 48 hours, will bring about marked improvement.[20] If the potassium by mouth is not effective, or if the patient is seriously ill, as with a dangerous arrhythmia, then the potassium may be given by the intravenous route, preferably with electrocardiographic control.

A useful solution is one which contains 3.0 Gm. (40 mEq.) of potassium chloride in 500 cc. of 5 per cent glucose in water administered in an hour or so. If a rapid atrial rate is not slowed by this drug, it is unlikely that additional potassium will be effective, but if the rate is slowed but a

normal mechanism is not re-established, then more potassium may be carefully given until the desired result is obtained. It should be remembered that it is possible to produce potassium intoxication, especially in elderly patients who do not tolerate the drug as well as others.

Procaine amide (Pronestyl) has been found to be useful in the treatment of the arrhythmias produced by digitalis toxicity.[20] This drug may be given by mouth in doses of 1.0 Gm. followed by 0.5 Gm. every three to six hours since the peak effect of the action which begins in a few minutes usually occurs in one hour or less and its effect is usually dissipated in a few hours. The drug may also be given as an intramuscular dose of approximately 1.0 Gm. followed by 0.5 to 1.0 Gm. at intervals of several hours depending upon the response. In addition, it may be given by vein with 50 mg. injected slowly every two minutes with determination of the blood pressure before each dose. With lowering of the blood pressure the interval between the injections is increased, and if the pressure continues to become lowered, then the drug is omitted. At the same time any expected potassium diminution should be corrected. Toxic effects of the procaine amide may include vertigo, marked lassitude and even an allergic reaction. It probably should not be used in the presence of complete heart block since it has been reported to produce ventricular fibrillation. There have also been reports of serious agranulocytosis after its use.[21]

On the basis of the demonstrated acute reduction of the serum calcium by means of the chelating agent sodium ethylenediamine tetraacetic acid (Na-EDTA), this preparation has been used to combat digitalis toxicity.[20] For this purpose it has been given intravenously, 600 mg. administered slowly over the course of one-half hour or more. Five times this amount has been given in a comparatively short period without serious toxic effects.

A suitable stable preparation for human use of potassium citrate is not yet available although this drug is highly effective in digitalis intoxication in experimental animals. It is our understanding that a satisfactory solution of this drug may soon be marketed.

The use of quinidine for the prophylaxis and abolishment of ectopic ventricular beats and ventricular tachycardia is well documented, but even when used in accordance with the well established dosage schedule, it is not without certain dangers. Nevertheless, it is a useful drug when carefully and intelligently used for this purpose.

Digitalis Therapy in Children

The use of digitalis in pediatrics is largely confined to the treatment of supraventricular tachycardias and arrhythmias and in congestive heart failure. The only true contraindication to the use of digitalis in infants and children is the presence of digitalis toxicity.

For a better understanding of the utility of digitalis, the clinical picture of congestive heart failure in children should be reviewed. The three major types of congestive failure, that is, right-sided, left-sided and combined right and left heart failure, may be encountered.

The primary symptoms of right-sided failure, which comprise systemic venous distention, hepatomegaly, rarely splenomegaly, and edema, including facial as well as peripheral edema, may be seen. Advanced cases can progress to ascites and anasarca. Pleural effusions and pericardial effusions are extremely rare in uncomplicated right-sided failure. Associated symptoms of weakness, fatigue, and signs of peripheral vasoconstriction manifested by cold hands and feet are often noted. Gallop rhythm and pulmonary rales may be found, and the x-ray picture usually reveals an enlarged heart with relatively clear lung fields. Electrocardiographic evidence of right ventricular hypertrophy and right atrial-type P waves is usually encountered. Pulmonary hypertension, pulmonary valvular obstruction, or tricuspid disease usually underlies uncomplicated right heart failure.

Failure of the left heart may occasionally be seen in coarctation of the aorta, aortic stenosis, mitral valve disease, systemic hypertension, and occasionally left to right shunts. Paroxysmal nocturnal dyspnea, orthopnea and cardiac asthma are not as common as in adults. Exertional dyspnea and coughing may be prominent symptoms, and the weakness, apprehension or mental dullness, together with the peripheral vasoconstriction and peripheral cyanosis with cold hands and feet, may be striking. Pulmonary rales and gallop rhythm are frequently noted. The x-ray picture of enlargement of the left side of the heart with pulmonary vascular congestion and the electrocardiographic findings suggestive of left atrial dilatation are helpful.

Although the uncomplicated types of right and left heart failure may be seen in children, by far the most common form is the combined type. Here the picture, in contrast to that of adults, is

Digitalization

ADULTS

Preparation	24 Hour Amount in Divided Doses Milligrams I.V.	24 Hour Amount in Divided Doses Milligrams Oral	Speed of Effect Hours I.V.	Speed of Effect Hours Oral	Maximum Effect Hours I.V.	Maximum Effect Hours Oral	Maintenance Dose Milligrams I.V.	Maintenance Dose Milligrams Oral	Daily Toxicity Range Milligrams I.V. or Oral	Duration of Toxic Effects Days I.V. or Oral	Duration of Action Days I.V. or Oral
Powdered leaf		1,800		1-2		24		100-200	200-300	1-4	14-21
Digitoxin	1.8	1.8	1/2-2	1-2	24	24	0.1-0.2	0.1-0.2	0.2-0.3	1-10	14-21
Digoxin	1.0-1.5	1.0-4.0	1-2	1-2	2	4-24	0.25-0.50	0.25-0.75	1.0	1	5-7
Lanatoside C	1.0-2.0	8.0-15.0	1/2-1	4-8	1/2-3	24	0.2-0.4	0.5-1.0	1.5-2.0	2	2-10
Gitalin		6.0		24-48		24-48		0.25-1.25	0.75-3.0	1-3	9-12
Strophanthin (Ouabain)	0.5-1.0		1/4-1		1-2		0.7-1.0			1/2-1	1-4
Scillaren (Oral) Scillaren B (I.V.) Squill	1.2	15.0-30.0	1	24	24	24	0.25-0.50		1.5	7	1-2

INFANTS AND CHILDREN[1]

Preparation	Oral (Elixirs, Tablets[2]) Digitalizing	Oral (Elixirs, Tablets[2]) Maintenance	Parenteral (Adult Preparations) Digitalizing	Parenteral (Adult Preparations) Maintenance	Comments
Digoxin Oral: Elixir of Lanoxin[3] 0.2 cc.=0.01 mg.	Infants<2 yrs. 0.03 to 0.04 mg./lb. >2 yrs.. 0.025 to 0.03 mg./lb.	Approximately 0.01 mg./lb. in 2 divided doses daily	I.V. and I.M.[4] approx. same 0.02 mg./lb. (Premature infants) approx. 0.015 mg. lb.	Approx. 1/4 digitalizing dose once daily	Mode of oral digitalization; 1/2 total dose initially; 1/4 total dose 6 hrs. later, repeated 6 hrs. Mode of parenteral digitalization: 3 divided doses over 12-24 hrs.
Digitoxin Oral: Digitaline Nativelle Pediatric Elixir[5] 1 cc.=0.05 mg.	Infants<2 yrs. 0.01 to 0.015 mg./lb. >2 yrs. approx. 0.01 mg./lb.	Approx. 1/10 digitalizing dose once daily	Same as oral	Same as oral	Modes of oral and parenteral digitalization: 1/2 total dose initially, 2 doses of 1/4 total dose at 6-8 hr. intervals
Lanatoside C	Do not use	Do not use	I.V. and I.M.[4] approx. 0.01 to 0.015 mg./lb.	Use digoxin, digitoxin or whole leaf preparations	Mode: 2/3 dose initially, remainder 2-4 hrs. later.

1. Over 10 years: lower limit of adult dosage.
2. Tablets may be used between 6 and 8 years of age.
3. Burroughs Wellcome & Co., Inc..
4. Not subcutaneously.
5. E. Fougera & Co., Inc.

SIGNS OF DIGITALIS INTOXICATION

1. Gastrointestinal: Anorexia, nausea, vomiting, diarrhea, salivation, abdominal cramps.
2. Cardiac: Premature ventricular beats (in children, premature atrial beats), slow coupled beat, partial or complete block, paroxysmal tachycardia, atrial or ventricular fibrillation, atrial standstill.
3. Neurological: Paresthesias, headache, restlessness, increased irritability, disorientation, changes in personality, stupor.
4. Visual: Dimness, inability to focus, scotomata, diplopia, yellowish vision.

most commonly associated with a precipitating respiratory infection. In addition to the causes of left failure mentioned, patent ductus arteriosis, ventricular septal defect, common truncus and, in the first month of life particularly, hypoplastic left heart syndrome and transposition of the great vessels are frequent causes. Tachycardias and arrhythmias, as well as myocarditis and fibroelastosis, are also common causes.

The symptoms are a mixture of those seen in right-sided and left-sided failure. The most prominent include tachycardia, tachypnea and hepatomegaly. It should be noted that in an infant systemic venous distention in combined heart failure may not be easy to see or demonstrate. Hepatomegaly is an important finding. In infants, generally, if the liver extends over one third of the way below the right costal margin in a line from the right nipple to the umbilicus, it is enlarged. Weakness, changes in mental alertness, cough, anorexia, and peripheral vasoconstriction often complete the picture of combined failure.

Congestive failure should be treated with digitalis. This use of the drug raises the question of differences between the infant and child and the adult with regard to digitalis. In general, premature infants are relatively sensitive to digitalis. Mature infants take relatively large amounts of digitalis, usually one and a half to two times the adult per pound dose, while in children over two years of age the lower per pound dose limits usually suffice. In addition, because many of the combined heart failures are precipitated by a respiratory tract infection, the end points for therapeutic effects of the digitalis are frequently not as sharp as in adults. For this latter reason dose ranges per pound of body weight are more important in children and infants than they are in adults. Further, the subjective toxic symptoms of digitalis which help in measuring adult dosage are not obvious in infants and small children; an infant, unable to complain of nausea, simply vomits.

It has been stated many times that in view of the multiplicity of preparations on the market with a relatively high degree of reliability, the physician should limit himself to use of two or three drugs at most, to accomplish digitalization, and thus be more familiar with them. At the present time digoxin is widely used and can be given by all routes. Lanatoside C is useful in intravenous therapy and digitoxin is still fairly widely used. See the accompanying tables for dosages of these drugs. Except in extreme emergencies, where intravenous therapy with lanatoside C is used, intramuscular dosage with digoxin is satisfactory and significant effects may be noticed from 30 minutes to two hours after an intramuscular injection. This preparation is well suited to intramuscular use, but should not be used subcutaneously, and obviously drugs should not be given intramuscularly in a grossly edematous site.

The end points to be noted include a drop in the heart rate, with due regard for the effect of fever or respiratory infection upon a sinus rate. Decrease in size of the liver, decrease in respiratory rate, and disappearance of rales and edema, as well as the general improvement in the patient's appearance and activity, are important. Loss in weight is also an important feature, except in infants where the small amount of fluid transfer is harder to detect. Electrocardiograms can be used to tell whether there is some digitalis effect or whether toxicity has occurred, but they do not tell whether the patient is clinically adequately digitalized. A decrease in heart rate, S-T T changes with shortening of the Q-T interval, and the development of a sinus arrhythmia point to digitalis effect.

Toxicity is usually present with first and higher degrees of atrioventricular block, ectopic atrial beats, paroxysmal atrial tachycardia with block, or other atrial arrhythmias. Ventricular ectopic beats, a common sign of digitalis toxicity in the adult, are not nearly as frequent toxic signs in infants and children as are atrial effects. It should be noted that the development of atrial tachycardia or arrhythmia during digitalis therapy in the pediatric age group should be regarded as due to the digitalis until clearly disproved. The rules for treatment of digitalis toxicity in children are the same as those for the treatment of adults. Here the advantage of using a relatively short-lasting drug, such as lanatoside C or digoxin rather than digitoxin, is important. If intravenous potassium salts are to be used for the treatment of digitalis toxicity, electrocardiographic monitoring should be carried out.

If digitalization by the parenteral route has been accomplished within a 24 hour period with digoxin, suitable maintenance dosage can be given orally, or the parenteral route may be maintained at about one fourth of the digitalizing dose. The maintenance dose for digitoxin is the same whether administered parenterally or orally, about one tenth of the digitalizing dose. If lanatoside C was used parenterally, the initial daily maintenance

dose of digoxin or digitoxin may have to be slightly greater than usual.

Supraventricular tachycardias and rapid arrhythmias in infants require digitalis as the drug of choice. These ectopic rhythms are more in the nature of an emergency than in most adults. Quinidine and or the Cardioverter may be used in place of or in addition to the digitalis in selected cases.

References are available from the authors upon request.

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Prevention of Hemorrhage After Tonsillectomy and Adenoidectomy in Children

II. Improvement in the Technique of Adenoidectomy

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In 1961 I reported the incidence of hemorrhage in 534 adenotonsillectomies.[1] I verified Emerson's findings that the closed fossa technique completely eliminates hemorrhage from the tonsil fossae.[2-4] Postoperative primary adenoid hemorrhage remained a problem that demands further attention. In these previous 534 cases, some troublesome adenoid bleeding occurred or threatened to occur in 29 per cent.

I have since made two changes in the method of removing adenoids. First, I discontinued using the LaForce adenotome, removing the adenoid tissue with sharp curets and punch forceps when needed. Secondly, and more recently, I have been observing the nasopharynx with a laryngeal mirror before and after curettage of the adenoid tissue. If the mirror is coated with pHisoHex and wiped clean with sterile gauze, it does not fog from the patient's hot breath. After all the adenoid tissue is removed, one, two, or three round gauze adenoid sponges are pressed tightly in the nasopharynx and left there during removal of the tonsils. When the sponges are taken out, the nasopharynx is inspected for possible bleeding points. If none are seen, the operation is ended. If an active bleeder is present, a postnasal pack is inserted and kept in place until the following morning. Should any bleeding occur in the recovery room or in the ward, an intramuscular injection of Premarin (one-half ampul), Adrenosem (1 cc.), or Koagamin (2 cc.) is given to the patient. These injections are varied or repeated every 15 minutes for three or four times. Should this treatment fail to control the hemorrhage, a postnasal pack is inserted if one is not already present. Otherwise, a transfusion of 250 or 500 cc. of whole blood is given.

Results

In this present series of 321 operations, primary adenoid hemorrhage occurred or threatened to occur in 55 patients (17 per cent). The threatened hemorrhage was eliminated by postnasal packs alone in 35 patients (11 per cent), and by postnasal packs plus one or more injections of coagulants in 8 patients (2 per cent). Some postoperative bleeding occurred in 12 patients (4 per cent) who did not have postnasal packs. This bleeding was controlled by medication (one to four injections) in 10 of these patients. The other two required blood transfusions.

One of the patients with a postnasal pack bled severely the following day when the pack was removed. Control of the hemorrhage required a blood transfusion. Subsequent tests showed this child had a prolonged prothrombin time.

One child with sickle cell anemia was operated on with no complication other than the precautionary insertion of a postnasal pack.

There were two cases of secondary adenoid hemorrhage, one on the sixth postoperative day and one on the seventh. One child required a postnasal pack, but in the other bleeding stopped after injection of an ampul of Premarin (20 mg.).

These results are presented in tables 1, 2 and 3.

Table 1. — Secondary Hemorrhage Following Adenotonsillectomy (331 Cases)

Tonsil Fossae	Adenoid Fossae
0 (0%)	2 (0.6%)

Table 2. — Primary Tonsil Fossa Hemorrhage (331 Operations)

0 (0%)

Table 3. — Primary Adenoid Hemorrhage (331 Operations)

Prevented by postnasal pack alone	35 (11%)
Controlled by medication alone	10 (3%)
Requiring pack and medication	8 (2%)
Transfusion	2 (0.6%)
	55 (17%)

Summary

The incidence of primary postoperative adenoid bleeding, actual or threatened, has been reduced from 29 per cent to 17 per cent by two changes in technique:

1. Discontinuation of the use of the LaForce adenotome. The adenoids are removed with sharp adenoid curets, supplemented by punch forceps when indicated.

2. Clear visualization of the nasopharynx with the laryngeal mirror to determine:
 a. If all the adenoid tissue is cleanly removed, and
 b. If active bleeders are present after removal of adenoid pressure sponges.

The number of patients receiving injections of coagulants postoperatively dropped dramatically from 23 per cent in the former series to 6 per cent in the present series.

The incidence of secondary adenoid hemorrhage, three to seven days postoperatively, remained unchanged at less than 1 per cent.

Primary and secondary hemorrhage of tonsil fossae is no problem.

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Phthiriasis Palpebrarum

Report of a Case

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Phthirus pubis (crab or pubic louse) involvement of the eyelashes is considered a rarity in present day practice.[1] Because of its infrequency, the following case is reported.

Report of Case

An 8 month old white male infant was seen on Aug. 16, 1956, in the Department of Ophthalmology at the Geisinger Medical Center, Danville, Pa. His mother had noted brown "specks" on the lashes of both eyes for several months, but no diagnosis had been made by his pediatrician. As we observed the many small dark particles, suddenly we saw one of them move. A cellophane tape slide was made of some of the material and both lice and nits of Phthirus pubis were seen under the microscope.

The lids were treated with 1 per cent yellow oxide of mercury ointment three times a day and when they were seen on August 30, two weeks later, only one nit was evident on the left upper lid. This was mechanically removed and the child was discharged.

A gynecologist found that the mother was free of pubic lice, but the father had the disease involving the pubic region. This was cleared in several days with treatment rendered by his private physician.

Comment

The group of Anoplura (sucking lice) is made up of Pediculus humanus capitis (head louse), Pediculus humanus corporis (body louse), and Phthirus pubis (crab or pubic louse). Usually the head louse breeds on the hair of the head and the body louse in the seams and linings of clothes and on chest and axillary hair, while the pubic louse breeds in the pubic and perianal regions. All three sometimes breed on the eyelashes;[2] however, the pubic louse is the one most frequently found on the lids. Unlike the head and body louse, the crab louse apparently does not transmit disease.

The reddish brown adult of Phthirus pubis (fig. 1)[3] measures 1 to 2 mm. in length, is nearly as broad as it is long, and has claws giving it the appearance of a crab. The adult lives about one month,[4] but will die in 24 hours if separated from the human body. It lays approximately two eggs

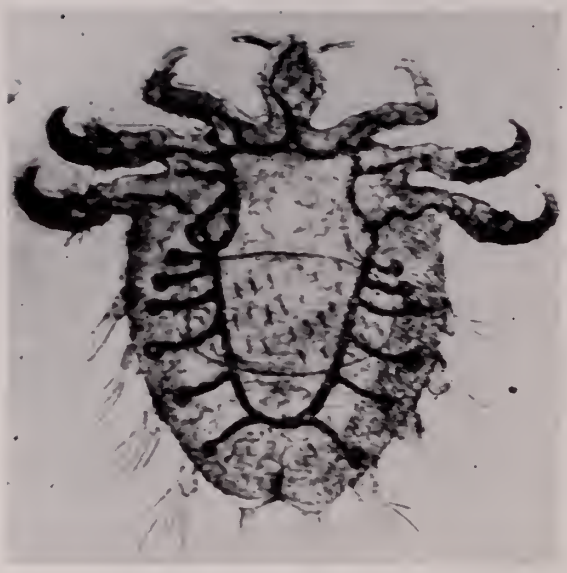


Fig. 1.—Phthirus pubis. (Sutton, Richard L., and Sutton, Richard L. Jr.: Handbook of Diseases of the Skin, St. Louis, The C. V. Mosby Company, 1949, p. 359.)



Fig. 2.—Nit on eyelash. (Friedman, R., and Wright, C. S.: Phthiriasis Palpebrarum; Report of a Case, Arch. Ophth. 11:996 (June) 1934.)

a day. The eggs incubate for six to eight days and the adult stage is reached in 15 to 17 days following three molts.[5]

The louse clings tightly to the base of the cilia with its head down and inserts its mouth parts into the soft tissue of the lid in order to feed on blood. This activity can result in urticaria, irritation, and itching which leads to scratching and inflammation of the lids and conjunctiva. Skin pigmentation can occur. Secondary infection may follow causing abscess formation and conjunctivitis. Phthiriasis has been reported as one of the causes of bloody tears.[1] Phthirus pubis causes a more severe lesion on the lids than the head and body louse because of its strong claws and sharp jaws.[2]

The usual spread of the crab louse is by physical contact or by the use of infested toilet seats or bed clothing. The scalp, armpits, and beard also can be infested by Phthirus pubis. Only occasionally are the lashes infested without pubic involvement.[6] Usually Phthirus pubis is transmitted to the eyes from the pubic region by the hands. Children most frequently experience lid involvement. When phthiriasis occurs in infants, it probably is transmitted by a parent. In the case reported it was apparently transmitted by the father. Goldman[7] reported a similar case.

The eggs of lice are commonly called nits (fig. 2)[8] and are found cemented to hairs in the affected area. The nits of the pubic louse are larger than those of the head and body louse and can be seen with the naked eye. They appear as a heavy dark powder on the lashes.

Infestation of regions other than about the eyes may be treated with 1 per cent gamma benzene hexachloride cream (Kwell) or benzyl benzoate compound containing DDT (Topocide). In treating the lids, the ophthalmologist can manually remove the lice and nits with forceps, under general anesthesia if necessary, or the lashes and eyebrows may be treated with a 1 to 2 per cent yellow oxide of mercury ointment applied three times a day.

Summary

A case of phthiriasis of the eyelashes in an infant is reported. Phthirus pubis is discussed with attention paid to its morphology, habits, transmission, signs and symptoms, and treatment.

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Appendicitis Caused by Gallstones

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It is a well known fact that appendicitis is often caused by obstruction of the lumen or focal irritation of the mucosa of the appendix. Many cases of appendicitis due to Enterobius vermicularis, Ascaris lumbricoides, Trichuris trichiura and of course the most common, fecalith, are on record. There is no record to my knowledge, however, of a case of appendicitis being precipitated by cholelithiasis. The following case is presented as an interesting variation of an old problem.

Report of Case

A 48 year old white male food handler in whom a duodenal ulcer had previously been diagnosed had been off his diet and had been asymptomatic for over a year. On the evening of May 24, 1963, he ate a large quantity of peanuts. He wakened the next morning nauseated and with pain in the right upper quadrant of the abdomen and in the epigastrium. He vomited most of that day and when he could vomit no more, he had dry retching.

The patient was seen for the first time on May 26, still with pain in the epigastrium and right upper quadrant of the abdomen and still nauseated. He was afebrile. Examination failed to reveal any tenderness in the lower portion of the abdomen, although the rectus muscles were tender. Bowel sounds were normal. There was no tenderness on rectal examination.

Either acute cholecystitis or a partial duodenal obstruction secondary to the known ulcer was suspected. The patient was admitted to the hospital where he was treated with intravenous fluids and anticholinergics and was given nothing by mouth. The day after admission a gastrointestinal series revealed an active duodenal ulcer and a gallbladder series was nonvisualizing. That afternoon the temperature rose to 102 F. The pain in the abdomen still was unchanged. The following day the gallbladder series was repeated with a double dose of dye and still was nonvisualizing. The temperature rose to 102 F. again on that day and antibiotic coverage was begun empirically. There was still no pain in the lower portion of the abdomen and the nausea was lessened.

On the third hospital day a partial obstruction of the small intestine developed at the terminal ileum. Roentgenograms of the abdomen confirmed the fact that this had not been present two days earlier as barium had passed freely into the colon. In fact, it was still in the colon in such quantity that obstruction secondary to the barium was entertained. A Miller-Abbott tube was passed, but after several hours the patient failed to show any progress and was taken to the operating room. At operation a gangrenous retroileal appendix was found in the lumen of which were several gallstones.

Discussion

The old cliché of "never try to make more than one diagnosis if it will explain all symptoms" certainly held up in this case. The patient had obvious gallbladder disease. He seemed to do well at first, but a relapse and an elevation of temperature occurred, an obstruction of the distal portion of the small bowel finally developing. A gallstone ileus was the prime suspect preoperatively. The finding of gallstones in the appendix was a surprise, but certainly harkened back to the old cliché.

Apparently the patient had an acute cholecystitis and passed some small stones, which became lodged in the appendix and set up appendicitis. The location of the appendix, high behind the ileum, no doubt helped conceal the diagnosis of appendicitis when the obstruction developed.

Summary

A case of acute appendicitis caused by gallstones passed during an attack of cholecystitis is presented. The unusual etiology of this common disease is believed to be of interest.

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President's Page

Having "grown up" in the Florida Medical Association, I find there are many subjects that should occupy my first President's Page, but after completing the appointment of almost 60 Committees, that subject is foremost in my mind.

"To the victor belongs the spoils" is the adage by which elected officers in many fields seem to function. No doubt it exists to a small degree with all officials, but Florida medicine has a working organization and through the years efforts have been made to appoint physicians who are known to be workers and thinkers. There are no spoils.

Last year President Quillian sent requests to all members asking those who were interested in serving to indicate their particular Committee interests. Many responded and their replies were catalogued. In January, I asked county society presidents to indicate physicians, particularly young ones, who had served well in local societies and were likely to be an asset to the Association. Several responded with lists of doctors which were likewise catalogued, although some arrived too late to be of value this year. Unfortunately, a moderate number of county societies usually do not respond to requests for information from your Association until three, or sometimes four, requests are sent, making it slow, difficult and costly to maintain the local action that so many of us desire.

Armed with these lists of workers and a knowledge of many doctors over the state, I set about the task of appointing Committees. Never have I been confronted by a more difficult and sometimes frustrating experience. In the first place a President is limited in the number of appointments he can make. Committees are appointed on a staggered basis so that there can be no drastic turnover at any time. Usually this plan permits the appointment of two Committee members by each President; one is limited to a particular district and one appointed at large. In some instances, Committees are at work on particular projects and the chairman requests that the appointments not be disturbed. Consideration was always given to this request. Several physicians occupied places on two or more Committees and a few even served as chairman of two, a fact which seemed unnecessary except in most unusual circumstances. This was discussed with these appointees and resignations were requested from all but one. All readily complied. Some Committee members who had not attended meetings or indicated interest in their Committees were likewise asked to resign or in isolated instances were removed. Council and Committee chairmen who had served four or more years were usually replaced unless they had an incomplete project. This change necessitated the removal of some of our most capable and most faithful workers who will undoubtedly be utilized again in our organization.

As can be seen, an attempt was made to find new faces to work in Florida medicine and to return old ones who are particularly capable. To a much smaller degree than I desired, this was successful. Appointments were discussed with Council chairmen and most new chairmen of Committees. It would have been desirable to talk to each appointee, but that was not possible. Cooperation was terrific! Only two refusals were encountered and both members gave justifiable reasons.

Men who may be controversial in their thoughts and actions in some respects but who stimulate thought and action in others were put to work. Men with selfish interests known to supersede their interest in the whole of Florida medicine were excluded when possible. Many doctors whom I respect, and admire and consider as friends were not included because positions simply were not available. Some of these had been asked their Committee interests and yet could not be appointed. To them I apologize. Vacancies will develop, new jobs will appear; they may yet be utilized.

To one and all, I express my appreciation. I request that Councils and Committees be active and if there are appointees who are not interested or who cannot serve diligently, I request their resignation so that others may be activated. Our foremost aim is an active and progressive Florida Medical Association.





The Limitist-A Rebuttal

In an editorial appearing in the March 1963 Journal, Dr. Willard E. Manry Jr., a member of the Florida Academy of General Practice, defended the philosophy behind the present fee schedule provided under Workmen's Compensation. This schedule makes no distinction between the services of a specialist for setting a difficult wrist fracture, to use Dr. Manry's example, and those of a generalist who sets these same bones in an easy, uncomplicated and therefore "profitable" case. This same writer indicated that any proposal to compensate adequately for the complicated case should be fought "tooth and nail." Although conceding that the specialist usually performs a more difficult procedure, Dr. Manry rationalized away the need for commensurate payment by insisting, in another example, that if an ear, nose and throat doctor will treat a cold, he competes with the generalists and loses his right to be recognized as a specialist. Instead he should be called a "limitist." A limitist, by Dr. Manry's definition, restricts himself to certain portions of the body, but will treat any ailment in this restricted sphere no matter how trivial. Thereby he loses his rights as a specialist so far as a fee is concerned. This writer leaves little doubt that most of us who specialize are actually limitists. We shall come in a moment to his highly original proposal as to how his true blue, nonlimitist specialist should be compensated.

First of all, however, let us look at how Dr. Manry's proposal hurts all doctors of whatever persuasion or degree of training. The system of free private enterprise manifests itself in medicine in the arrangement known as fees for services. If doctors are consistently paid less than the true worth of their services, those services will deteriorate in quality and the system may fail. In an era of threatened government participation in medicine, a great disservice is done to the entire profession if we must negotiate and find that one subgroup of doctors insists that all broken wrists or all heart attacks are the same with no distinction as to the care and skill required. This view will quickly lead, as it already has in Workmen's Compensation and in some insurance policies, to the setting of a price for all broken wrists and all heart attacks regardless of severity. This "average rate" once established, we have seen, quickly becomes the "top rate" allowed for this category. How can this fail to happen if some doctors will testify that all cases in a given broad diagnostic category are alike? Only doctors can force the recognition of a distinction, a gradation of skills, and Dr. Manry will not do this. I wonder if an internist should bow out of a case of uncomplicated myocardial infarction if it appears that the patient is not going to have an arrhythmia or an embolus, or be precipitated into congestive failure? If he does not do so, he would appear to live under the danger of Dr. Manry's judgment.

Pointing out that his ideal specialist handles only difficult cases, the writer of the editorial then throws him to the wolves with the statement, "A doctor of this type should have no fee schedule." Supposedly, the patient is to be given to understand that since his case is beyond the generalist's competence, he might just as well prepare to sign over all of his worldly goods in advance of seeing this exalted personage. How far behind the times can Dr. Manry get? The general public insists that a doctor place some valuation on his services in advance and in some recognizable frame of reference. To do so is sometimes very difficult, but the majority of practicing physicians have already shown their willingness to meet this demand. We "limitists" want to be placed neither on an impossibly high cloud of Dr. Manry's fashioning, nor on the same plane as the generalists who are performing the simpler services. There is an equitable place in between based on the realities of practice, and the cause of medicine can only be served if all doctors work together toward finding it.

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Association News

Major subjects on which the House of Delegates took action at the 113th annual convention of the American Medical Association, held in San Francisco June 21-25, 1964, included tobacco and health, human rights, physician-hospital relations, continuing medical education, the cost of medical care, and federal subsidization of prepayment plans and health insurance companies. Approving a strong stand on tobacco and health, the House called cigaret smoking "a serious health hazard" and declared that "the American Medical Association is on record and does recognize a significant relationship between cigaret smoking and the incidence of lung cancer and certain other diseases." It urged that programs be developed to disseminate vital health education material on the hazards of smoking to all age groups through all means of communication.

On the issue of human rights the House declared itself "unalterably opposed to the denial of membership, privileges and responsibilities in county medical societies and state medical associations to any duly licensed physician because of race, color, religion, ethnic affiliation, or national origin." It urged all state medical associations, all component societies, and all individual members "to exert every effort to end every instance in which such equal rights, privileges and responsibilities are denied."

The House adopted recommendations designed to serve as guidelines for physicians in meeting such problems of physician-hospital relations as: appointment of salaried chiefs of staff; appointment of salaried heads of clinical departments; appointment of salaried directors of medical education; employment of salaried physicians for outpatient and emergency departments; use of salaried physicians to provide care ordinarily provided by interns and residents; and utilization of closed panel prepayment medical care programs by hospitals. The report containing these recommendations also stressed the imperative need for the medical profession to assume responsibility for the quality, continuity, and availability of professional services and for the coordination of these services with the other essential supportive aspects of health care.

An Association-sponsored survey and accreditation program in continuing medical education was authorized by the House. In the program attention will be concentrated on institutions and organizations offering courses rather than on individual courses. Appraisal will be carried out only at their request and eventually only these institutions and organizations and the courses they offer will be included in the annual lists of "Continuing Education Courses for Physicians."

The AMA Commission on the Cost of Medical Care submitted its four volume report to the House. Its conclusions and recommendations will be studied and reported on at the 1964 Clinical Convention. The House reaffirmed the Association's policy favoring federal grants for funds for construction and renovation of medical schools, hospitals, related institutions, and mental health centers, but urged that the advantages and desirability of multiple source financing be kept clearly in mind.

The House went on record as opposing federal subsidization of prepayment plans and health insurance companies. It opposed a poll of the Association members concerning compulsory Social Security for self-employed physicians and also opposed polls of the membership on issues of "great or even moderate importance" because the House members express the majority sentiments of their constituents on all questions coming before the House. Approval was given to an expanded program on medical ethics and to a three point communications program designed to improve the public relations position of the medical profession.

Miscellaneous actions included approval of creation of a Section on Allergy, a comprehensive inquiry into the causative factors for the sharp increase in syphilis and gonorrhea, and a national conference on areawide planning of hospitals and related health facilities. The House also agreed to broaden studies on the problems of unwed mothers, illegitimacy and other related matters. It supported a position statement on protecting children against physical abuse and agreed that a forum for representatives of national medical specialty societies and the American Academy of General Practice be held on Nov. 1, 1964, in Chicago. In addition, it recommended that the Board of Trustees use the talents of Dr. Edward R. Annis, immediate past president, and other qualified spokesmen for medicine with appropriate remuneration. The House requested clarification of the ethical and legal limitations of physicians participating in court-ordered, pre-trial psychiatric examinations and urged the Association to continue its vigorous opposition to tax regulations discriminating against "professional associations" and "professional corporations" and its support of legislation which seeks to provide tax equality with business corporations for these professional organizations.

Six of the seven resolutions submitted by the Florida delegation were adopted in principle. The subjects of these resolutions were: Corporate Status for Physicians to Apply to U. S. Internal Revenue Code; Smoking and Health; Medical Care for the Aging; Need for Family Physicians; Specialty Medicine, and Welcome to AMA. The resolution on AMA Prepaid Life Membership was referred to the Board of Trustees for further study.

Dr. Annis, of Miami, outgoing President, was succeeded in office by Dr. Norman A. Welch, of Boston, who chose for his inaugural address the theme of "Unity in Medicine." Dr. Donovan F. Ward of Dubuque, Iowa, Vice President of the Association, was named President-Elect and will assume office at the June 1965 annual convention in New York City. Dr. Alvin J. Ingram, of Memphis, Tenn., was elected to the Board of Trustees. Dr. Irvine H. Page, director of research of the Cleveland Clinic, received the AMA 1964 Distinguished Service Award for his investigation of cardiac, vascular and renal disease. The AMA Scientific Achievement Award was given to Prof. Rene Jules Dubos, Ph.D., of the Rockefeller Institute, New York City, and the Joseph Goldberger Award in Clinical Nutrition to Dr. William J. Darby, of Vanderbilt University School of Medicine, Nashville.

Final registration figures reached a grand total of 49,437, including 14,229 physicians. The entire Florida delegation was in attendance with the exception of the chairman, Dr. Reuben B. Chrisman Jr., who was unable to attend because of illness in his family. Dr. Robert E. Zellner, his alternate, was seated in his stead.

Respectfully submitted,
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Meredith Mallory, M.D.
Robert E. Zellner, M.D.
Francis T. Holland, M.D., Acting Chairman

Clinical Comment



Florida Orthopedic Society Fall Meeting

The annual fall meeting of the Florida Orthopedic Society was held in October. Abstracts of papers comprising the scientific program follow:

"Conservative Treatment of Abduction Fractures of the Femoral Neck," Richard A. Worsham, M.D., Jacksonville.—The author presented nine patients who had sustained fractures of the femoral neck with clinical stability following the injury with a valgus relationship between the head and neck of the femur. Fractures were treated by bed rest, immediate chair privileges and crutches without weight bearing until union was demonstrated by x-ray. Stress was placed upon the necessity for the absence of any significant deformity at the fracture site in both the anteroposterior and lateral view, and it was noted that all the patients were women in the general age range of 45 to 50 years.

"Posterior Dislocation and Posterior Fracture —Dislocation of the Humerus," Jos. H. Dimon III, M.D., Atlanta, Georgia.—Posterior dislocation of the shoulder is a rare condition and is divided into three categories: (1) posterior dislocation following febrile illnesses with convulsions or electroshock therapy and presumably due to muscular wrenching; (2) fracture dislocation of the shoulder as the result of direct trauma; and (3) nontraumatic dislocation as the result of congenital hyperextensile joints. In all three categories it was pointed out that the anteroposterior x-ray view is seldom diagnostic and may in fact appear almost normal in that an axillary lateral view of the shoulder is required for diagnosis. The end results of surgical treatment of these various categories were discussed.

"Congenital Absence of the Femur," William J. Hutchison, M.D., and Francis T. Holland, M.D., Tallahassee. — The authors discussed the possible etiologic factors in congenital absence of the femur and thought that most likely external environment influences this anomaly at the critical time of organ development and is the most likely cause. The therapeutic management of the patients revolves about obtaining stability at the hip and fitting them with prostheses to overcome the severe leg length discrepancy. The authors presented two patients in whom they had established hip stability by the surgical production of an acetabular shelf to stabilize the deformed proximal femur and two other patients who were being treated in abduction splints in a conservative effort to produce a similar shelf. They stated that the patients walked better with the foot as a base in the prosthesis, although with obvious cosmetic deformity. They presented two patients in whom the foot had subsequently been amputated following hip stabilization and stated their gait was not as good as it was prior to the amputation of the foot although they thought the gait was improving and expected continued improvement.

"Tibia Vara," Robert P. Keiser, M.D., Coral Gables.—The author presented 23 cases of tibia vara or Blount's disease. After a review of the pertinent literature, the cases were divided into those appearing in the early years of life termed infantile in type and those appearing in later years in life termed juvenile in type. They are to be distinguished from the physiological varus deformities of the extremities in young children and by the abrupt deformity at the knee rather than the general curve of the physiological deformity. The infantile type of the disease is best managed conservatively with braces, and the author presented illustrations of successful management by this nonoperative treatment. In those patients who did not respond to conservative care, lateral closure of the proximal tibial epiphysis was utilized in an attempt to obtain correction of the deformity during the growing years, and in those patients in whom this method failed to correct the deformity satisfactorily, osteotomy of the proximal tibia was advocated after cessation of growth. It was pointed out that if osteotomy was performed prior to cessation of growth, the deformity was likely to recur and the patient was likely to require repeated osteotomies to maintain a satisfactory result.

"The Pathogenesis of Discogenic Backache," Carroll B. Larson, M.D., Iowa City, Iowa.—The author presented a basic discussion of the known pathogenesis of discogenic backache. He present-

ed evidence that the normal intervertebral disk operates under 30 to 35 pounds of hydraulic pressure in the upright position and that this hydraulic pressure is contained by the annular and longitudinal ligaments of the spine. This pressure is the result of the migration of fluid or imbibition into the semigelatinous nucleus of the disk. The author thought that deformity of the nucleus of the disk altering the hydraulic stresses on the annular ligament and stimulating C-fibers demonstrated in the longitudinal ligaments produces backache without nerve root involvement. These variations in hydraulic pressure result from traumatic or degenerative change with biochemical reflections in the ground substance of the annular ligament. Associated with these basic findings the author presented clinical examples of disk deformity both by physical examination and x-ray. He also stated that the secondary cause of deformation of the intervertebral disk is muscular imbalance between the extensors of the trunk and the abdominal muscles acting as flexors. Conservative management of these problems was then presented and discussed in some detail both by the author and members of the society.

"The Scope of Fat Embolism," Walter C. Jones III, M.D., Coral Gables.—The author presented a review of the incidence, etiology, clinical science, differential diagnosis, diagnostic aids, and methods of treatment of fat embolism. This material was illustrated with a report of two fatal cases of fat embolism following fracture of the tibia in one instance and fracture of the femur in the other.

"The Orthopedic Surgeon and Rehabilitation," Augusto Sarmiento, M.D., and Newton C. McCollough III, M.D., Miami.—The authors traced the evolution of rehabilitation services following World War II and pointed out that, in 1958, 80 per cent of orthopedic rehabilitation was being carried out by physiatrists who had formed and administered rehabilitation centers. Diseases such as cerebral palsy, muscular dystrophy, arthritis, poliomyelitis and paraplegia and treatment of amputees had passed from the traditional orthopedic pattern into management by physiatrists. The authors noted that in these circumstances the orthopedic surgeon was relegated to the role of a surgical technician at the behest of the physiatrist and thought that this did not represent the best interest of the patients. They described the formation and administration of a rehabilitation center at Jackson Memorial Hospital in Miami supervised by the orthopedic surgical service. Points of interest were the low hospital stay for patients with these chronic problems, averaging 22 days, and the establishment of group physiotherapy which the authors thought demonstrated some of the ancillary benefits of group psychotherapy in elderly patients with rehabilitation problems.

"Two-Plate Fixation of Femoral Shaft Fractures," Ronald J. Mann, M.D., Miami.—The author presented a review of the literature on the use of two-plate fixation in the treatment of fractures of the femoral shaft. He discussed the operative technique and presented 20 cases. Postoperatively the patients were treated in balanced suspension and allowed to ambulate on crutches without weight bearing. In all cases presented union had taken place between 14 and 24 weeks postoperatively. The author pointed out that this method of treatment did not supersede conservative care in traction or the use of an intermedullary rod for internal stabilization and pointed out that it should be reserved for those cases which by virtue of the types of injury or other ancillary problems are not suitable for conservative care.

Resident's Award

The society has established an annual award for the best manuscript on orthopedic research by residents in training in the state of Florida. Manuscripts were judged by Dr. Baxter L. Clement of Ft. Lauderdale, Dr. William J. Hutchison of Tallahassee, and Dr. James West of Sarasota, Chairman. The award was presented to Dr. Steve H. Gilman of the University of Florida in Gainesville who presented an experiment in which he had done simultaneous homogenous autogenous transplants of the metatarsal shafts of rabbits at intervals varying from two to 12 days following the first transplantation. The transplants were retransplanted back into the original donor animal. Twenty-one days following the second retransplantation, the specimens were obtained for histological study. The author pointed out that the survival time of homogenous bone grafts is nine days in varying species. He demonstrated that irreversible changes occur in the cells of homogenous bone transplants six days after transplantation. He concluded that metabolic changes occur in transplanted cells 48 to 72 hours before these changes can be detected by conventional histologic techniques.

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1. Roach, T. C.: Therapy of Peptic Ulcer, J. Louisiana Med. Soc. *115*:136-139 (April) 1963.
2. Steinberg, H., and Almy, T. P., Drugs for Gastrointestinal Disturbances, Chapter 21, in Modell, W. (editor): Drugs of Choice —1964-1965, St. Louis, The C. V. Mosby Company, 1964, p. 343.

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News

The Fall Meeting of the Florida Orthopedic Society is being held at the International Inn in Tampa beginning on Friday afternoon, September 25 and ending with a business meeting on Sunday morning, September 27, according to announcement by Dr. William J. Hutchison of Tallahassee, program chairman of the Society.

The Annual Fall Meeting of the Florida Society of Anesthesiologists will be held on October 10 at the Hotel Singapore at Miami Beach.

Dr. G. Dekle Taylor of Jacksonville has been appointed Florida State Chairman of the Deafness Research Foundation.

The Eighth Program of Postgraduate Medical Education for Latin American Physicians is being held at the University of Miami School of Medicine during the months of August, September and October. Participating in a symposium on the formal organization of American Medicine on September 9 will be Dr. Warren W. Quillian of Coral Gables, Immediate Past President of the Florida Medical Association; Dr. Homer L. Pearson Jr. of Miami, Secretary of the Florida State Board of Medical Examiners, and Dr. DeWitt C. Daughtry of Miami, President of the Dade County Medical Association.

The Seventh Annual Medical Progress Assembly sponsored by the Birmingham Academy of Medicine has been scheduled for September 13-15 at the Parliament House in Birmingham. A total of 22 hours of Category I credit will be allowed by the American Academy of General Practice for the programs.

The Third Annual Physicians' Seminar on Respiratory Diseases will be held at the Cherry Plaza Hotel in Orlando on Saturday and Sunday, September 12-13. Out-of-state speakers include Dr. Leighton Cluff of Baltimore, Dr. Joseph W. Peabody Jr. of Washington and Dr. John H. Seabury of New Orleans.

The Postgraduate Seminar of the Duval County Medical Society has been scheduled for September 26-27 at the Hotel Robert Meyer in Jacksonville.

in the overweight stable adult

...fasting serum levels of insulin are usually normal, postprandial levels excessive[1-3]

...insulin acts in adipose tissue via hexose monophosphate shunt, principal path of glucose conversion to storage fat[1,4]

...excessive endogenous insulin acts to stimulate lipogenesis and weight gain[1,3,4]



The 15th Annual Scientific Assembly of the Florida Academy of General Practice is being held aboard the Italian cruise ship M/S Riviera sailing from Fort Lauderdale on October 31 for Ocho Rios and Montego Bay, returning to Fort Lauderdale on November 5. The program, co-sponsored by the Florida Medical Association and in cooperation with the University of Florida College of Medicine, will be presented by 18 speakers. Physicians from Florida participating include Drs. Lester R. Dragstedt and Richard P. Schmidt of Gainesville, and Drs. J. Brooks Brown and G. Dekle Taylor of Jacksonville.

Dr. Alan Cazort, Professor of Allergy at the University of Arkansas School of Medicine at Little Rock, was the guest speaker at the meeting sponsored by the Okaloosa County Medical Association on July 14. Invited guests included members of the Walton County Medical Association, the Santa Rosa County Medical Association of physicians at Eglin Air Force Base. Arrangements for the meeting, held at the Officers Beach Club on the Base, were made by Col. Adanto A.S. D'Amore.

Meetings

August

Florida Proctologic Society, August 13-14, Buccaneer Inn, Jekyll Island, Georgia

Fourteenth Annual Postgraduate Obstetric-Pediatric Seminar, August 20-21, Daytona Plaza Hotel, Daytona Beach

September

Physicians' Seminar on Respiratory Disease, Third Annual, September 12-13, Cherry Plaza Hotel, Orlando

Florida Orthopedic Society, Fall Meeting, September 25-27, International Inn, Tampa

Postgraduate Seminar of the Duval County Medical Society, September 26-27, Hotel Robert Meyer, Jacksonville

Twelfth Annual Diabetes Seminar, September 30-October 2, Balmoral Hotel, Miami Beach

October

Florida Society of Anesthesiologists, October 10, Hotel Singapore, Miami Beach

Scientific Assembly Cruise, Florida Academy of General Practice, M/S Riviera, Leaves Fort Lauderdale, October 31, returns November 5

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1. Gordon, E.S.: Metabolism 11:819, 1962. 2. Grodsky, G.M. et al.: Metabolism 12:278, 1963. 3. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 4. Sadow, H.S.: Metabolism 12:333, 1963. 5. Faludi, G.: J. Am. Med. Women's Assoc. 18:722, 1963. 6. Faludi, G.: Geriatrics 18:452, 1963. 7. Williams, R.H.: Textbook of Endocrinology, Ed. 3, Saunders, Phila., 1962, p. 610. 8. Weller, C. and Linder, M.: Am. Therap. Soc., June 1963. 9. Moss, J.M. et al.: Med. Times, July 1964.

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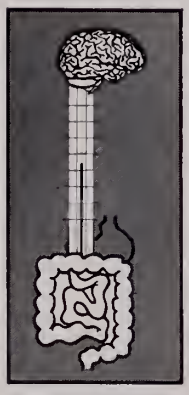
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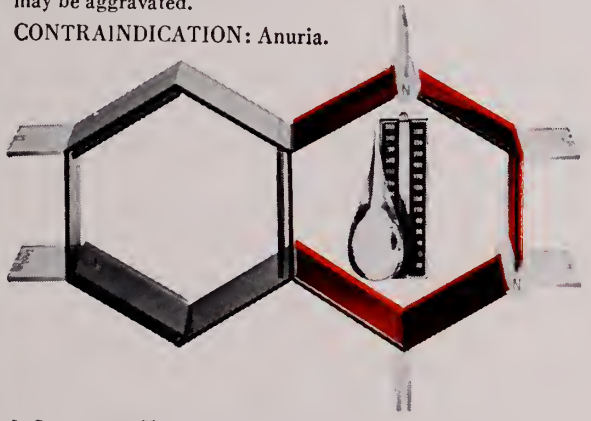
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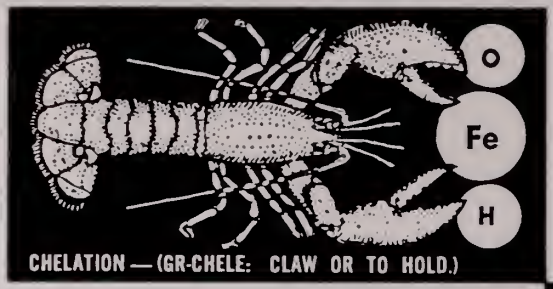


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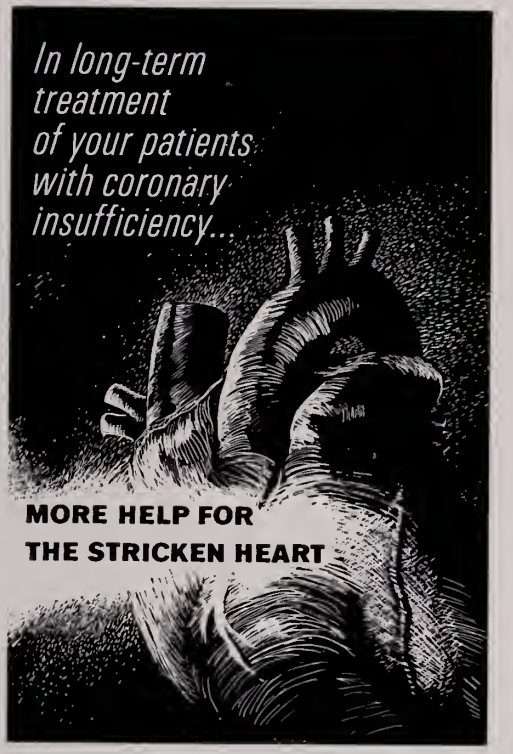
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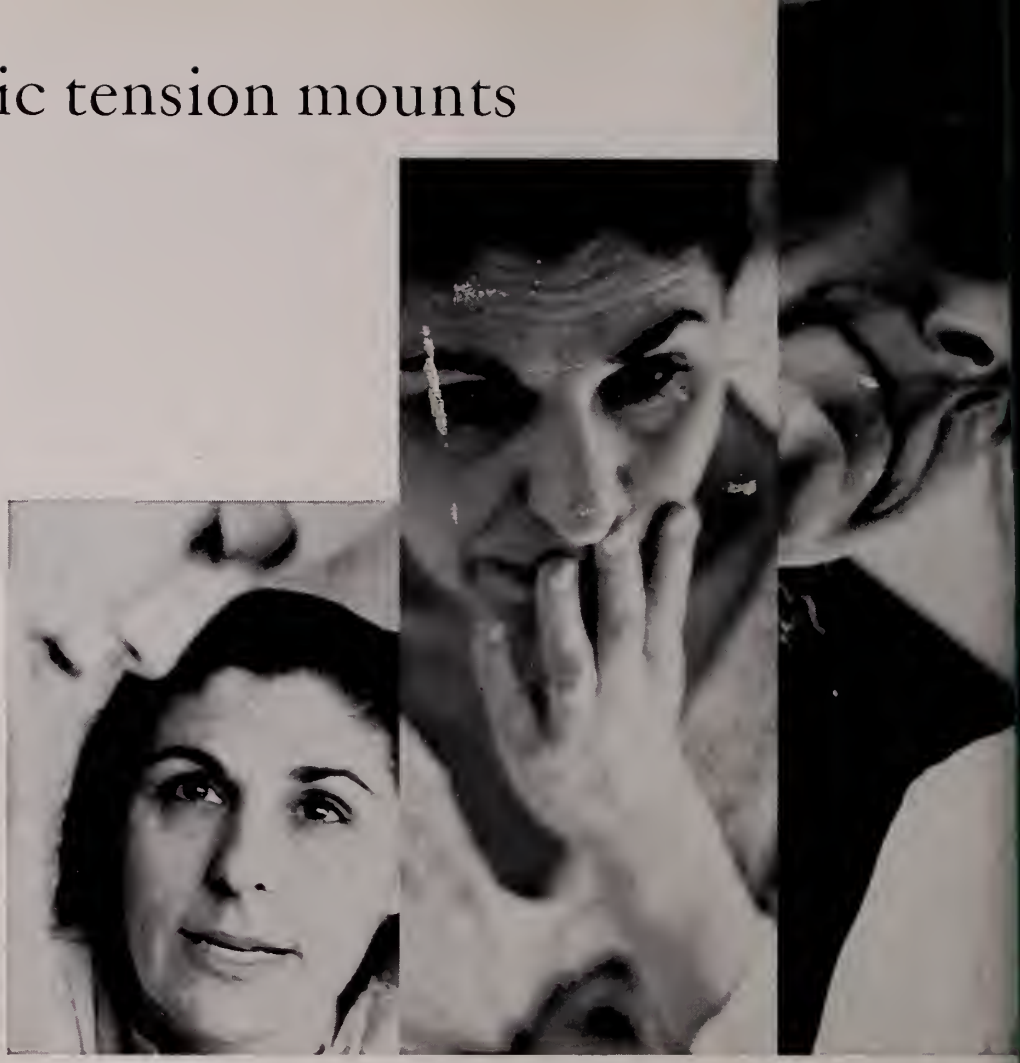
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Mild to moderate psychoneurotic reactions: Manifested by anxiety-tension alone or with depressive symptomatology, agitation, restlessness, psychophysiological disturbances	2 mg to 5 mg, 2 or 3 times daily
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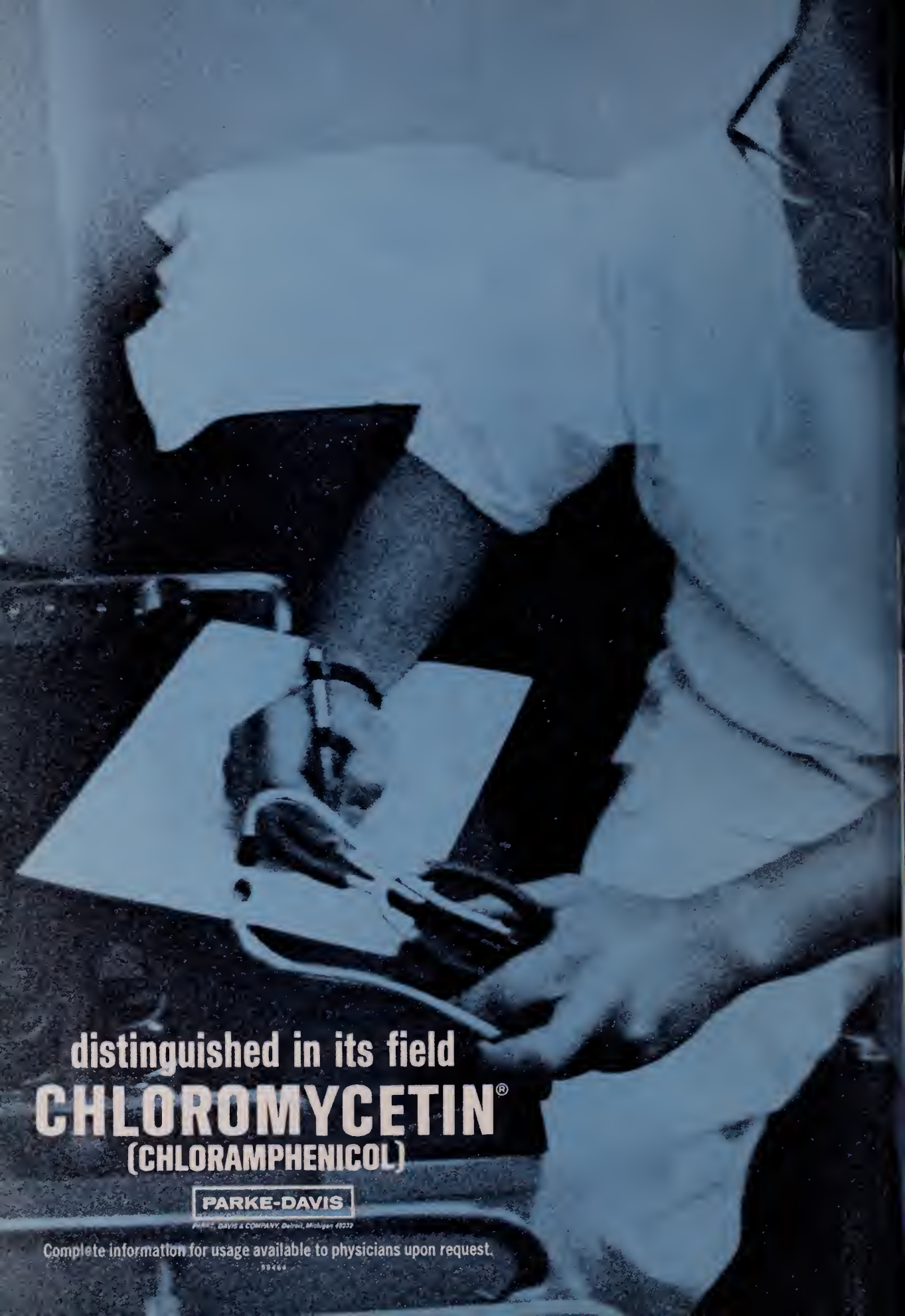
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Abscess, pulmonary	17	16
Bronchiectasis	19	13
Bronchitis	286	267
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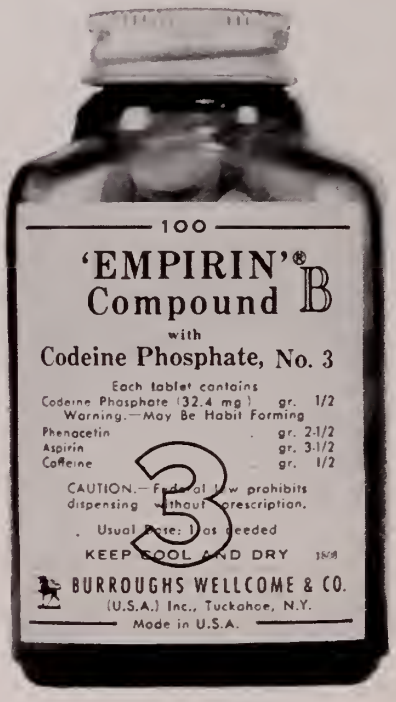
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*Adams, J.: J. Tenn. Med. Ass. 50:446, Nov., 1957.

Condition	No. of Patients	No. Cured with Signemycin
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Chattas, A. et al.: Antibiot. Med. 7:300, May, 1960.

Condition	No. of Patients	No. Cured with Signemycin
Eye, ear, nose, throat infections	368	343
Respiratory infections	369	346
Gastrointestinal infections	42	30
Skin and soft-tissue infections	38	37
Deep-seated or generalized infections	47	44
Various conditions	157	150
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Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

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Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

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Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

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Condition	No. of Patients	No. Cured with Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

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Contraindications: Hyperexcitability, hyperthyroidism.

Before prescribing, see SK&F Product Prescribing Information.

Supplied: Bottles of 50 capsules.

1. Dorfman, W., and Johnson, D.: *Overweight Is Curable*, New York, The Macmillan Company, 1948, p. 16.

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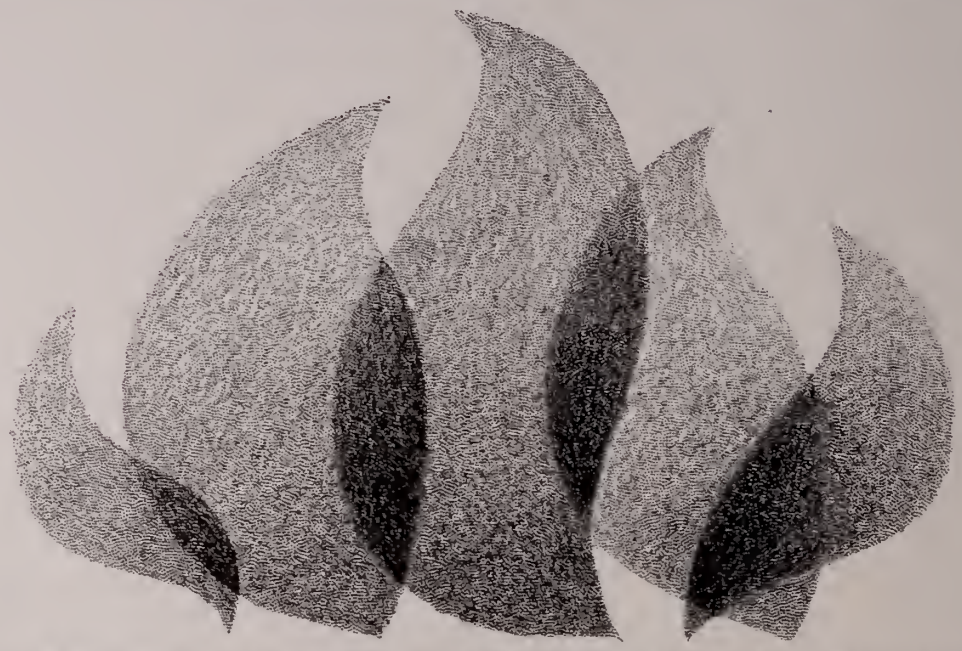
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sometimes cause wakefulness; course of adm
tration should not exceed eight weeks at a t
Consult product brochure for complete informa

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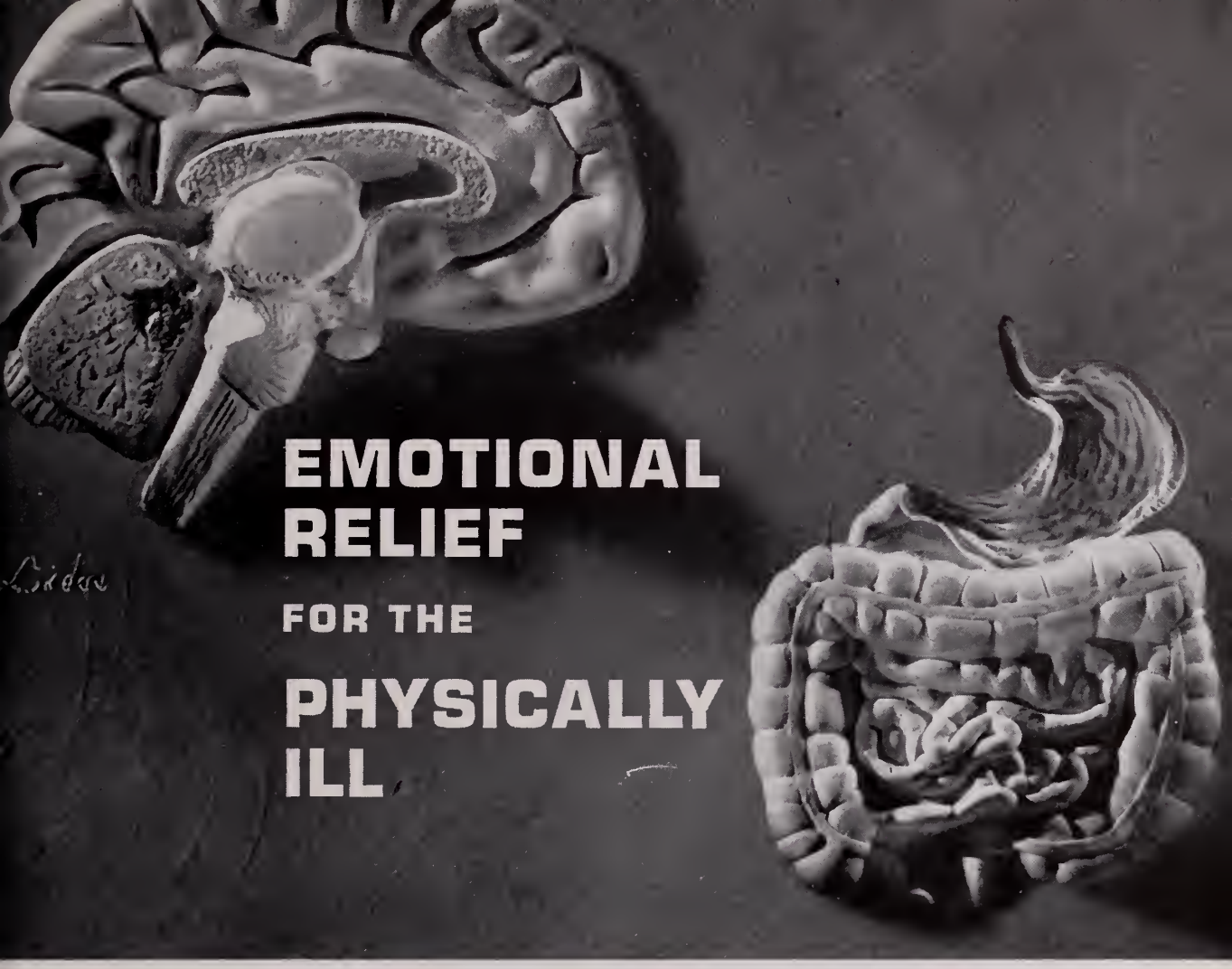
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The JOURNAL
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Symposium on Myocardial Infarction

William M. Straight, M.D.
Guest Editor

In the succeeding pages five prominent cardiologists of Florida discuss several practical aspects of myocardial infarction. This disease, the first correct antemortem diagnosis of which was made but a scant 63 years ago, is now one of the most common causes of death. Even, however, in this day of sophisticated diagnostic instruments and therapeutic means available in the farthest reaches of our state, mistakes of omission and commission continue to be made in the diagnosis and treatment of this disease. It is hoped that the articles comprising this symposium will sharpen the reader's acumen and stimulate him to more accurate diagnosis and more effective therapy of this common disease.

Coronary Proneness Can It Be Identified?

Paul N. Unger, M.D.
MIAMI BEACH

Is the characterization of a coronary-prone individual justifiable? Do current facts warrant the separation of such an individual from the remainder of the population? Can he be identified and, if at all, with what degree of accuracy? Finally, having identified him, what methods of therapy, if any, are available to modify the inevitable course of his disease?

The answer to the first question is probably a qualified "yes," realizing that present criteria are guidelines rather than absolute facts. With close to 525,000 deaths in the United States from coronary artery disease in 1962 and the threat that this figure will grow even larger, one cannot afford to wait until all the facts are discovered. If these factors could be detected and evaluated early enough in life and prior to the appearance of clinical symptoms referable to ischemic heart disease, the inevitable succession of events leading to development and progress of this disease might be modified.

Before proceeding to an enumeration of these factors, certain basic background information must be introduced. The developmental progress of atherosclerotic lesions as shown at post-mortem and by experimental production can be summarized briefly. Musculoelastic thickening is found in the first decade of life with differences noted between sexes even at this early date. Fatty streaks occur in the second decade; fibrous plaques in the third; complicated lesions in the fourth; and clinically manifest disease in the fifth decades. Thus critical lesions occur in the coronary vessels 20 or more years before clinically manifest coronary artery disease. The fibrous plaque found in the third decade of life is directly associated with the development of ischemic heart disease. The coronary-prone individual must

be discovered as early in his disease process as possible since present evidence indicates that with the appearance of the fibrous plaque the reversibility of the lesion is lost. Whether modification of predisposing factors which effect the production of the fibrous plaque can affect the end result will take years to evaluate, but a start must be made. The attempt is certainly worth the effort since means of modification of these adverse factors can be undertaken utilizing measures which, on the whole, carry no risk.

Predisposing Factors

Limitations of space permit no more than enumeration and the briefest consideration of these factors. The serum cholesterol level is well established as being directly related to the development of atherosclerotic heart disease on a group basis, but it does not always predict the extent of the fibrous plaque on an individual basis. Forty per cent of white males in the 40 to 50 year age group who die in accidents have extensive atherosclerosis of the coronary arteries. This figure increases to over 50 per cent in the 50 to 60 year age group. Very few competent observers have any doubt about the relationship between the level of serum cholesterol and the risk of coronary artery disease. A stepwise increase in the risk of coronary artery disease with elevation of the serum cholesterol has been demonstrated. The properly done serum cholesterol determination is as good a predicative measurement and is easier to perform than beta-lipoproteins, beta-lipoprotein glycosides, or triglycerides. There is urgent need for a reliable and easily performed fat tolerance test as one means of finding the coronary-prone individual.

Genetic factors are definitely involved, but there is no absolute evidence to date to indicate the manner in which they operate. Perhaps it is through their effect on lipids, the anatomic configuration and angle of coronary artery branching, the relationship of the vessels to the surrounding cardiac muscle bundles, the intimal thickness and permeability, the relationship to hypertensive disease, or the presence of occult or frank diabetes. Purely physical factors such as the Reynolds number, the Bernoulli effect, and Poiseuille's law may also be important determinants. While, for example, intimal thickening is favored by high velocity flows, high perfusion pressures favor the formation of atheroma. Sayers' studies relating flow pressures with ion transport may prove to be extremely important. Humoral factors of interest relate epinephrine and norepinephrine release with the mobilization of fat, and adrenal steroids probably have an effect on lipids and the development of atherosclerosis. Hypertension and its known accelerating effect on the development of coronary artery disease may be related to any number of the factors previously discussed.

The role of diabetes as an accelerator of the rate of development of atherosclerotic heart disease is beyond doubt. It has been shown that by the time carbohydrate tolerance fails and becomes clinically manifest as diabetes, the disease process has been actively progressing for some 20 years. By that time there are already well developed changes in the vessel walls. Diabetes may exert its effect through alteration of the glycogen cycle, an effect on mucopolysaccharides and glucuronates in the vessel wall, effects on intimal cell permeability and the precipitation of fats in the vessel wall. Every clinician is aware that poorly controlled diabetes can mean an elevation of the serum cholesterol and related lipids which will resist all measures directed towards their reduction until the diabetes is controlled. It should be urged here not only that regular checks of blood sugar levels of individuals whose antecedents are diabetic should be made early in life, but also that the full glucose tolerance test or the provocative glucose tolerance test should be more frequently utilized. Significant results can be achieved by the earliest identification of these individuals.

Other Related Factors

Up to the present, there have been identified the factors related to coronary proneness concerning which there can be little or no argument: family history, serum cholesterol, hypertension, and diabetes. What follows falls into relatively gray areas of current knowledge.

Hyperuricemia in and of itself has not been shown to be of importance. The combination, however, of hyperuricemia, hypercholesterolemia, diabetes, and modest to significantly elevated hemoglobin and hematocrit levels is significant. The elevation of three or all four of these factors is frequently associated with demonstrable coronary artery disease. The role of gross serum lipescence and moderate polycythemia affecting increased rouleaux formation with coating of the coronary intima and consequent decreased perfusion of oxygen and other nutrients across the endothelium may be operative here. To date, blood coagulation studies as related to predictability of risk factors in coronary heart disease are of

no value. Much has been written relating the value of exercise in reducing the death rate of coronary artery disease. A careful analysis of data shows that vigorous, regular physical activity exerts a salutary effect on coronary heart disease only when hypertension is present. It is ineffective in the absence of hypertension. Smoking is definitely related to incidence of deaths in established coronary artery disease. Its role in the absence of established disease or predisposition to disease is subject to considerable question. Obesity in the absence of hypertension and hypercholesterolemia is not directly related to the development of ischemic heart disease. Obesity, however, predisposes to the development of hypertension and hypercholesterolemia, thus making the maintenance of the ideal weight a worthy effort.

Conclusion

Statistical data concerning the factors mentioned are overwhelmingly convincing that they play a significant role in the causation of atherosclerotic heart disease. Based on current knowledge, atherosclerotic heart disease can be significantly modified by a preventive approach.

1680 Meridian Avenue.

Atypical Symptoms in Myocardial Infarction

Henry R. Cooper, M.D.
FORT LAUDERDALE

The symptom complex of myocardial infarction is remarkable in its specificity. The description of chest discomfort varies little from patient to patient. Indeed, relatives, neighbors, or passers-by make the correct diagnosis with dismaying ease and frequency. The almost monotonously reliable common features of the symptoms of a coronary accident enable the amateur to equal the professional in diagnostic accuracy in a majority of instances. Unfortunately, the amateur almost equals the professional in his prognostic ability as well, for, in any single instance of this disease the rule is absolute unpredictability. The situation being thus, it behooves the physician, in this day of heart consciousness and widespread lay publicity with regard to this most common major disease, to be familiar not only with the usual symptoms of myocardial infarction, but also with the less typical features.

Typical Symptoms of Myocardial Infarction

The chest sensation is described as a sense of constriction, tightness or pressure located substernally and often radiating to the throat or upper left arm. Unlike simple angina, the intensity of the pressure is usually painful and is so expressed by the patient. It lasts from 30 minutes to several hours, waxes and wanes in intensity, and is not related to position, respiration, swallowing or moderate movement of the chest wall. The victim prefers to remain still. Associated pallor, weakness, sweating, and some degree of dyspnea, apprehension and gastrointestinal disturbance are present. If the intellectual ability or descriptive facility of the individual is limited, the "language of the hands" is characteristic in expressing the location and character of the pain, and to some degree its intensity. The patient's hands are placed over the anterolateral aspect of the chest and pressed inward in a squeezing gesture, or one hand may be placed over the midsternum and pressed down firmly. Verbally or by gesture the patient indicates the size of the painful area to be at least as large as his hand. Nausea or vomiting may or may not be present, but medication may alter this.

In summary, the classical symptomatic features are: (1) Location—substernal; (2) Area—hand-size or larger; (3) Character of the sensation—pressure; (4) Intensity—painful; (5) Radiation—throat and upper left arm; (6) Duration—30 minutes or more; (7) Relationship—unrelated to bodily function or moderate chest wall movement; (8) Associated symptoms—pallor, weakness, sweating, dyspnea, apprehension and gastrointestinal disturbance.

Variation in the Common Symptoms of Myocardial Infarction

The location of pressure often extends from the substernal area and covers the entire anterior chest, and is described as a squeezing, crushing, tearing, pushing, heavy, aching, burning, weight-like, constrictive bandlike, or expanding ("bursting") pain. To convey the sense of weight the patient's expression is usually embellished by indicating that someone or something is sitting on the chest (as a truck, ox, or elephant). Rarely is the pain described as stabbing or sharp, and the closer to the cardiac apex the patient indicates the center of the pain to be, the farther away the physician walks from the diagnosis of myocardial infarction. The radiation of pain often extends beyond the throat and inner aspect of the left upper arm to include the angle of the jaws, the lower teeth, or the side of the neck. There is often an associated heaviness or aching of both arms. Ulnar radiation into the forearm, ring finger, and little finger is helpful in diagnosis. Spot pain, such as a tightness of the wrists or aching in the elbow, is not infrequent. Radiation through to the midback is rare, but referred pain to the lower cervical and upper dorsal back area is not uncommon. The important point is that despite rather remote and prominent radiation, substernal oppression is almost invariably present to some degree.

The most common variation in the relationship of pain is aggravation by respiration, and restlessness in the occasional person who cannot remain still but walks back and forth throwing his arms about dramatically.

In addition to classical symptoms there occur varying degrees of syncope and palpitation, both of which may be due to arrhythmias, heart block, or secondary autonomic imbalance.

Atypical Symptoms of Myocardial Infarction

The most atypical symptom of myocardial infarction is the absence of pain. Syncope may mask the pain, and, if it does, it usually occurs at the onset of the coronary accident. This has led to the statement that myocardial infarction should always be suspected in a patient in whom low blood pressure, weak pulse, pallor and sweating persist for a long time after syncope.[1] Some patients have neither syncope nor pain, and in such cases other characteristics must lead to a diagnosis.

Atypical location of pain also occurs. This has long been recognized, and indeed, it is not uncommon to hear cardiologists say that any pain above the waistline may be due to myocardial infarction. In my experience, if a patient has had a site of chronic inflammation or discomfort, particularly above the level of the umbilicus, the pain of the myocardial infarction may be centered there. For example, it may be in the right shoulder with chronic bursitis, or along the line of a previous left thoracotomy scar. Occasionally this atypical pain may be most dramatic, as in one patient with excruciating pain located solely over the left kidney with a nephrostomy tube in situ. The patient rapidly went into shock with an acute posterior infarction. Sometimes radiation sites unrelated to previous disease may be the most prominent subjective complaint. These include headache, pain in the hard palate or sinuses, and severe posterior pain in the neck. In addition, although sharp, stabbing, knifelike or cutting pain is rare, it does occur. Finally, atypical pain of myocardial infarction may be coexistent with acute disease of other organs. The obvious disease of the other organ absorbs the physician's attention and the myocardial infarction is missed. This is particularly true of cholecystitis, but can occur with any acute abdominal condition.

On occasion paresthesia replaces the usual retrosternal pressure. This was exemplified in a 32 year old husky man who complained of "tingling like mild electricity" in the anterior chest for 10 to 15 minutes, associated with moderate dyspnea. His electrocardiogram slowly evolved as an anterior infarction in the subsequent 10 days.

In the absence of any chest sensation, "substitution symptoms" or "equivalents" of acute myocardial infarction usually are present. These are the associated symptoms of autonomic imbalance or stress (pallor, sweating, weakness, vomiting, mental aberration, bradycardia or tachycardia, and even profound shock), or the symptoms of left ventricular dysfunction, such as dyspnea and cough, ventricular tachycardia, or other arrhythmias. A frequent atypical picture is dyspnea with weakness and nausea and little or no chest discomfort, but with associated pallor and sweating. A bizarre picture in the presence of infarction was one of a man with an acute onset of weakness, sweating, and a sensation of being chilled to such a degree that he immersed himself in a tub of hot water for relief.

Conclusion

The more experienced the clinician, the greater is his appreciation of the wide variation in the symptoms of myocardial infarction. It is by this appreciation aided by corroborative laboratory procedures that the professional will exceed the amateur in the diagnosis of this disease.

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Deceptive Electrocardiograms in Coronary Disease

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The electrocardiogram is the most valuable instrumental aid in the diagnosis of myocardial infarction due to atherosclerotic heart disease. All too frequently, however, the diagnostic import of the electrocardiogram as well as the vectorcardiogram suffers from either overinterpretation or underinterpretation. Many authors have described incidents where overinterpretation has resulted in iatrogenic disease attended by needless hospitalization and loss of time from gainful employment.[1,2] Equal in incidence, although less frequently stressed, are the patients with coronary artery disease who are inadequately treated because of failure to recognize atypical and less frequent abnormalities in the electrocardiogram. Admittedly both extremes, overinterpretation and underinterpretation, create heavy penalties for the patient. Potentially, however, the more dangerous error is the one of omission. Acute atherosclerotic heart disease is characterized by an unpredictable course. It is paramount that recognition of this, the most prevalent and deadly disease of our day, be established as early as possible in order to initiate effective care. A few examples of atypical features in the electrocardiogram of patients with coronary disease are presented in order of frequency.

Septal Infarction, Septal Fibrosis, or Incomplete Left Bundle Branch Block

Normal septal activation from left to right producing an initial r wave in V4R, V1 or V2 is reversed. This is a result of infarction of the left side of the septum or because of incomplete left bundle branch block in the absence of gross infarction but usually associated with scattered fibrosis of the left septal mass. The depolarization pattern in one or more of the right precordial leads consists of a qrS deflection[3] (fig. 1). The initial q wave reflects right to left septal activation. The succeeding activation of the free wall of the right ventricle tends to cause positivity over the right precordium indicated by an upstroke which crosses the isoelectric line to produce a small r wave. The following S wave represents negative potentials transmitted during activation of the free wall of the left ventricle.

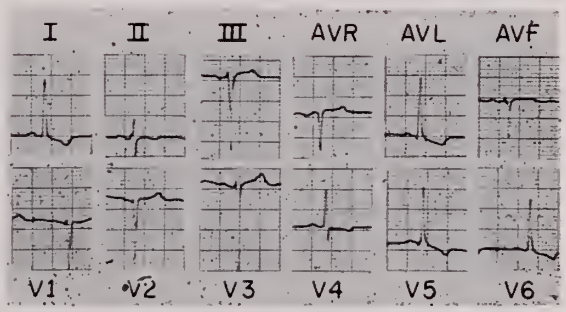


Fig. 1.—A minute' q wave followed by a small r wave is present in V1 and V2. Note absence of q waves in leads 1 and V6.

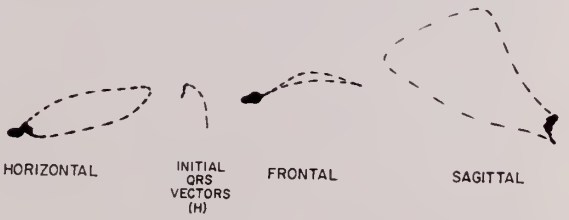


Fig. 2.—Initial QRS forces in the horizontal and sagittal planes are directed posteriorly. "Z" curve is seen in the first 30 msec. of the horizontal plane. Two legs of the "Z" are shown enlarged in the trace above (H).

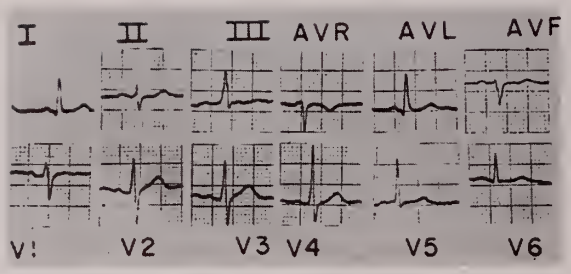


Fig. 3.—Prominent and widened R waves in V1 and V2 result from reduction of posterior forces.



Fig. 4.—The major portion of the horizontal loop lies in the anterior half. Significant diminution of forces can be seen in the left posterior quadrant. Counterclockwise rotation and horizontal axis of the frontal loop differentiate this characteristic SVCG of true posterior infarction from that of right ventricular hypertrophy in rheumatic mitral stenosis.

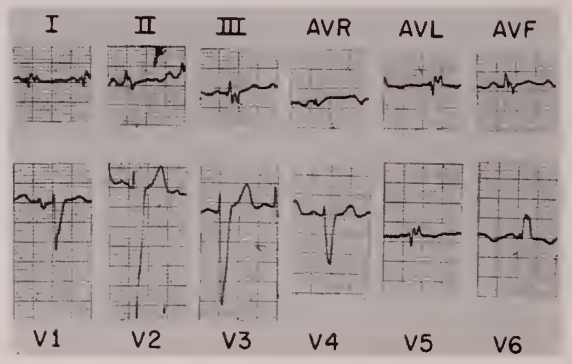


Fig. 5.—Initial r s precedes the RR' of complete left bundle branch block in V6.

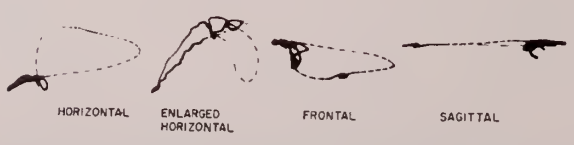


Fig. 6.—The first 30 msec. in the enlarged horizontal plane shows a small anterior loop. Its magnitude relationship to the major loop is seen in the first trace on the left.

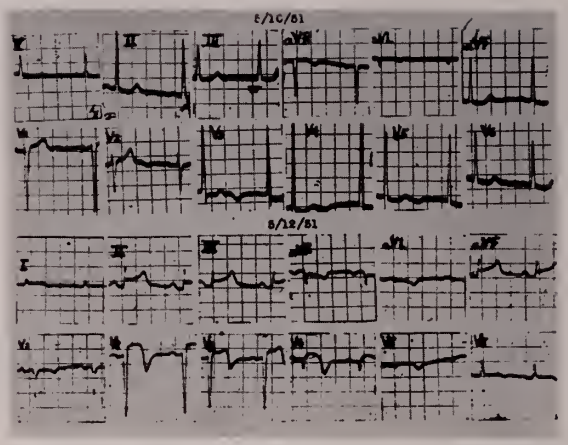


Fig. 7.—Negative U waves in V2, V3, V4 and V5, on May 10, 1951, preceding clinical myocardial infarction. Two days later typical acute electrocardiographic changes after clinical myocardial infarction.

The characteristic vectorcardiogram (Frank technique) records a "Z" curve in the initial 25 to 30 msec. of the horizontal loop (fig. 2).

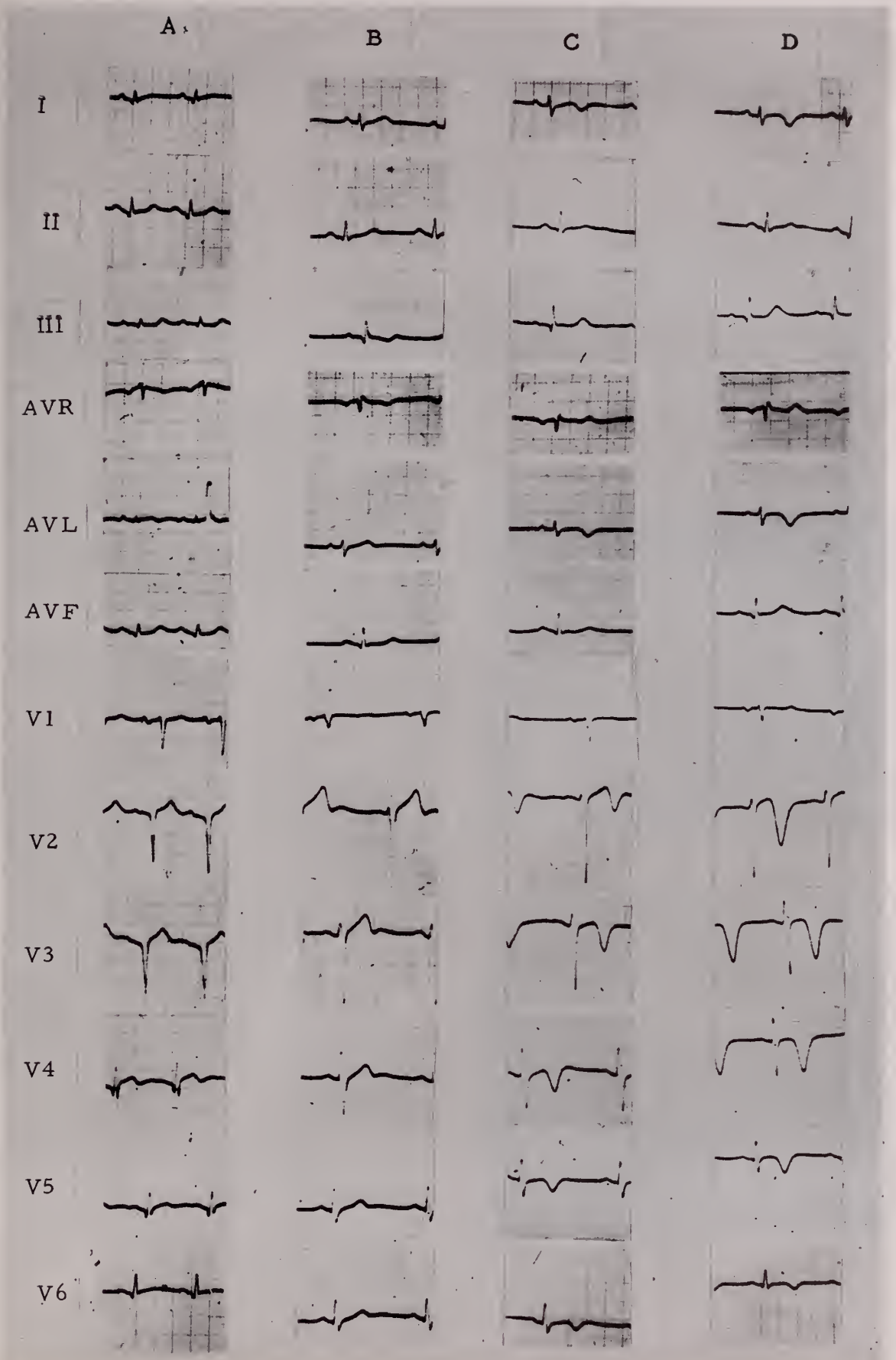
True Posterior and Posterolateral Wall Myocardial Infarctions

A significant loss of viable myocardium in the posterior or posterolateral wall of the left ventricle will result in abnormal Q deflections in those leads which reflect epicardial potentials of the posterior aspect of the left ventricle. Electrode positions over the back record minute deflections too small to interpret. Under these circumstances the right precordial electrode positions V4R and V1 will often record tall and wider R waves associated with S waves of decreasing depth (fig. 3). These represent the inverse of the abnormal Q deflections that would be recorded by direct leads over the epicardial surface of the posterior aspect of the left ventricle.

The vectorcardiogram in true posterior infarctions clearly indicates the loss of posterior forces and associated increase in magnitude of the anterior forces (fig. 4). The horizontal loop is distorted so that a major portion lies in the anterior half. The differentiation from right ventricular hypertrophy is made by the presence of a vertical axis and clockwise rotation of the loop

Right

Fig. 8.—A. Clinical acute myocardial infarction with the initial electrocardiogram revealing loss of R in V2, V3, and Q V4, V5 also cove plane ST-T in AVL and V4. B. Tracing 24 hours later with reversal of initial abnormalities. C. and D. Typical evolutionary changes 48 and 96 hours after onset of myocardial infarction.


A
B
C
D
I
II
III
AVR
AVL
AVF
V1
V2
V3
V4
V5
V6

in the frontal plane in right ventricular hypertrophy.

Complete Left Bundle Branch Block and Myocardial Infarction

The difficulties inherent in the diagnosis of myocardial infarction in the presence of complete left bundle branch block are well known. The reason for these is the right to left septal depolarization in left bundle branch block which gives rise to positive deflections in leads which reflect electrical potentials of the epicardial surface of the left ventricle. Infarction of the left septal mass or free wall of the left ventricle in the presence of complete left bundle branch block will therefore fail to produce Q waves in leads reflecting left ventricular epicardial potentials. When the intraventricular septum is electrically inert because of replacement of myocardium by scar tissue, Q waves are recorded in leads reflecting left ventricular epicardial potentials. These Q waves represent activation of the free wall of the right ventricle recorded from precordial left ventricular leads. This finding is well known as being diagnostic of septal, anteroseptal or posteroseptal infarction in the presence of complete left bundle branch block. Little known is the alteration that may occur in the first ascending R wave in complete left bundle branch block. Slurring and notching in the first 2 mm. of the initial R wave are the equivalent of a Q wave and have the same diagnostic significance (fig. 5).

The vectorcardiogram will reveal anterior deviation of the first 25 to 30 msec. in the horizontal loop (fig. 6). The remainder of the horizontal loop will be either a narrow clockwise or counterclockwise loop directed posteriorly and to the left.

Inverted U Waves

The U wave, a small, slow deflection, following the T wave and considered in the past to represent an after potential is probably the T wave of the Purkinje fiber in the light of recent work.[4] The U wave is normally positive when the T wave is positive. In the last 15 years increasing attention has been focused on this small deflection especially in serum potassium abnormalities. A relatively infrequent but highly significant finding is the presence of an inverted U following an upright T wave. This abnormality when present with angina is frequently associated with an impending myocardial infarction (fig. 7). When seen following an exercise tolerance test it is diagnostic of a positive test.

On occasion a normal electrocardiogram is recorded during the early evolutionary changes of an acute myocardial infarction. The fact that this is seen even when the earlier tracings of the preceding days recorded the usual characteristic features of an acute myocardial infarction, makes knowledge of this possible occurrence important. The sequence of events is as follows: The first one to three tracings record characteristic repolarization changes that are seen in the early stages of an acute myocardial infarction. A serial tracing then reveals a normal electrocardiogram without the current of injury or abnormal Q waves that were seen in the preceding electrocardiograms. Subsequent tracings again show the usual evolutionary changes of an acute myocardial infarction (fig. 8). The importance of this atypical evolutionary stage is: 1. It may mislead the physician into thinking that a myocardial infarction has not occurred. 2. Since this atypical evolutionary stage may occur at any time in the first 72 hours of a myocardial infarction, it may very well be the initial tracing (determined by the time after onset that the electrocardiogram is taken) and its normal appearance be responsible for an incorrect diagnosis even in the face of typical clinical features of a coronary thrombosis. Therapy will thus be delayed or withheld during a very critical period.

Summary

Proper application and use of a laboratory tool in clinical medicine obviates sins of omission as well as commission. In many diseases failure to recognize the finer aspects of a laboratory examination will result in consequences more hazardous to life than iatrogenic disease due to overinterpretation. Atherosclerotic coronary artery disease, because of its prevalence, unpredictability, and high mortality rate, is included in the former.

A few simple but infrequently stressed electrocardiographic signs of coronary artery disease are described in order to improve accuracy in interpretations.

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Cineangiography-Its Value in Diagnosis of Coronary Artery Disease

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Every practicing physician has been faced with the problem of deciding whether a certain patient does or does not have coronary artery disease. Under most circumstances a correct decision can be made with a good history and physical examination, laboratory tests, and if sufficient time allows, a therapeutic trial. There are some cases where the physician remains in doubt and where a correct diagnosis is particularly important. It is in just such a situation that cinecoronary angiography can play a decisive role.

Cineangiography of the coronary arteries was developed as a technique by F. Mason Sones, M.D., of the Cleveland Clinic, in the latter half of 1959. This has been proved to be a much safer test than originally thought so long as warning signals are observed. The mortality figure for the largest reported series is 0.17 per cent.[1] In our laboratory the mortality has been zero. The morbidity is minimal even though the procedure may require anywhere from one to four hours to perform adequately. The patient is awake in order to insure maximum safety, and he experiences only moderate discomfort at the site of the cut down for the catheter insertion. This is usually over the brachial artery. Most of the procedure involves maneuvering the special catheter into the orifice of each coronary artery, so that selective, small injections of dye may be made (fig. 1). The cineangiograms taken during the dye injections show the heart in motion thus revealing blood flow, flexibility of arteries, and whether a tortuous artery contains lesions or is merely tortuous.

It is important to know whether one or both arteries are diseased, and, if so, to what extent. A single severe lesion may be more important than many minor ones. For example, the physician might be undecided about giving the patient an anticoagulant. If he finds an almost completely obstructed artery, he will feel more certain about starting therapy. Figure 2 represents the left coronary study of a 57 year old woman who was thought to have coronary disease. By history she had several episodes typical of coronary occlusions, but at no time was there a significant serum glutamic oxalacetic transaminase elevation or electrocardiographic change. She was seen also during frequent hyperventilation episodes. The illustration verifies the fact that she has a markedly obstructed anterior descending branch of the left coronary artery, but fortunately the obstructed areas have been bypassed by a collateral vessel that supplies the distal portions of the artery. As a result of the cineangiogram the patient was started promptly on anticoagulant therapy, and, although she still has frequent chest pain two



Fig. 1.—Normal right coronary artery.



Fig. 2.—Left coronary artery of 57 year old woman. Large circumflex branch is normal. Anterior descending branch displays two obstructions—arrows on right. Arrow on left points to collateral vessel bypassing obstructed areas.



Fig. 3.—Right coronary artery of 26 year old woman. Complete obstruction is seen beyond tip of arrow with small collateral vessels in area of lesion allowing filling of distal artery.

years after this study, she has not yet suffered a myocardial infarction.

Numerous patients thought to have disease have been found to have normal arterial networks. These patients were studied primarily because there was some factor that did not fit the usual picture of coronary artery disease. Once normal arteries are found, attention can be focused elsewhere in attempts to relieve patients of their symptoms. A true cardiac neurotic patient may recognize the normalcy of his heart after he himself has viewed the cineangiograms, but then may direct symptoms toward another part of the body. There are many instances, however, where patients were completely rehabilitated by allowing them to resume exercise, by discarding drugs, or by returning them to full occupational activities when no coronary disease was found.

Coronary studies are particularly important when evaluating an adult patient for aortic or mitral valve surgery inasmuch as cases are recorded in most centers where the valve surgery was successful but associated coronary disease resulted in death during surgery or in the immediate postoperative period. If coronary artery surgery is contemplated, cineangiography is a must beforehand. The lesions will be observed so that the physician can determine not only the feasibility of surgery but also the type of surgery necessary as well as the site to be attacked.

The prognosis may be of such importance that a patient with definite coronary disease should undergo cine-coronary angiography to determine the extent of the lesion. One such instance is represented by a 26 year old woman who had a myocardial infarction in 1963. She has a family of three young children to rear, one of whom already has a significant cholesterol elevation, as does the patient. Figure 3 illustrates her right coronary artery revealing complete obstruction of the artery. It is apparent that the prognosis is rather poor because of the markedly elevated cholesterol in combination with the narrow arterial channels supplying the cardiac muscle. (The lesion and collateral channels are much more vivid when viewing the films in motion than when printed as a single picture.)

Comment

Despite its usefulness, cine-coronary angiography need not be employed whenever coronary disease is suspected. The mere documentation that there is coronary disease present may not justify such a test in the eyes of many. Whenever there is doubt of the existence of disease, or when proper therapy is uncertain, or if there is a sociological, legal, or economic problem combined with the patient's illness, it behooves the physician to use all means available to obtain factual data. Cine-coronary angiography may provide such previously unavailable answers.

From the Cardiovascular Laboratory of the H. Milton Rogers Foundation for Heart Research, St Petersburg, Florida

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Pabalate (Robins) is one of those euphonic product names which have intrigued us because it contains alternating vowels and consonants—something of a rarity in a word of 8 letters. Can you think of other drug names of similar structure?

Current Therapy of Acute Myocardial Infarction

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Despite the large numbers of patients treated annually for myocardial infarction, there is a surprising divergence of opinion regarding such measures as length of bed rest, anticoagulants, oxygen, and quinidine. Since the available literature is so voluminous I shall not attempt to summarize it, but shall offer my own program for treatment without bibliography, statistics, or undue detail as to drug dosages.

The previous articles have emphasized the difficulties sometimes encountered in establishing the diagnosis. A suspected case should be treated as proven until coronary disease has been conclusively ruled out. Hospitalization is highly desirable not only for ease in obtaining laboratory confirmation of the diagnosis, but also for prompt recognition and treatment of various complications which may arise.

The goal of treatment is not merely survival but restoration of the patient to his maximum level of physical and mental ability. This involves guarding against undue apprehension or depression of the patient during the acute phase of the illness and an orderly and progressive program of physical exercise after the acute stage has passed. A hopeful and realistic attitude is warranted by the fact that most patients recover and return to their previous employment.

Initial Considerations

Control of pain and apprehension with adequate doses of narcotics, given intravenously or combined with atropine if the pain is extreme, should be the first consideration. Dimenhydrinate (Dramamine) or prochlorperazine (Compazine) may be given simultaneously to prevent nausea and provide mild sedation. Narcotics are frequently given in place of hypnotics for the first few nights. It is necessary to instruct the patient with previous angina which disappeared on rest to ask for an injection if pain recurs since it usually does not disappear by itself. Other details of importance are restriction of visitors, efforts to keep outside noises at a minimum, and reassurance on the part of the doctor by his words, actions, and frequency of visits. The seriousness of the immediate situation needs to be appreciated both by the patient and the family to obtain full cooperation; I have found the American Heart Association's booklet, "Heart Disease Caused by Coronary Atherosclerosis" quite useful in helping the patient and his family understand the problems involved in treatment.

For the first few days diet should be restricted to liquids and very soft foods, low in salt unless the patient is hypotensive. Salt substitutes are allowed if salt is restricted, but coffee and iced food or drink are not permitted. He should be fed by the family or nurse for the first two to three days in the average case. When the patient requests more food he is allowed a 1,200 calorie soft diet with moderate restriction of fats. (Since the general public is so aware of the possible role of cholesterol-containing foods in the genesis of arteriosclerotic heart disease, the patient may become upset if he finds butter or eggs on his tray.)

The patient is reassured that no bowel action is expected for the first several days. A stool softener is routinely given with the addition of a mild laxative or use of a glycerin suppository if indicated. The bedside commode is used for bowel movements unless shock is present. Male patients are also allowed to stand with help to void if they are unable to use the urinal while supine. An indwelling catheter is occasionally necessary if the patient cannot void without considerable difficulty.

For the first three to four days the patient is kept at bed rest but encouraged to roll from side to side and move the extremities. The bed bath is deferred for 24 to 48 hours only in acutely ill patients. After 4 days, if the patient's condition seems stable, I allow the patient to sit in a comfortable chair with support for the head as long as he is comfortable. The exertion of getting in and out of bed is reduced to a minimum by help of nurses or orderlies. The number of times out of bed is increased to three, and timed so that he

may eat while sitting up. Bathroom privileges are granted the patient to walk to the bathroom after the tenth day of illness, with a wheel chair being used if the bath is not adjacent to the bed.

Smoking is forbidden during the period of hospitalization and for the month following. Patients are encouraged to give up the habit entirely. I condone smoking during the acute phase only if the patient is extremely restless and difficult to manage otherwise.

Oxygen is used only if the patient is in shock, congestive heart failure, or extremely restless and apprehensive. It is discontinued gradually, first at meals, and then for increasingly long periods during the day.

Anticoagulants are given for at least four weeks in all cases except the most elderly, or in those with hemorrhagic disease, peptic ulcer, liver failure, or recent hemorrhage. Phenindione (Danilone, Hedulin) is the drug I have found most useful because of its fairly prompt onset and offset of action. I rarely use heparin. Prothrombin times are determined daily at the start and then every other day up to the time of discharge. In general, anticoagulants are continued indefinitely.

Blood Pressure

Disturbances of blood pressure, either hypotension or hypertension, are frequently transitory and subside with reassurance and relief of pain. A patient with previous hypertension will often have rather dramatic lowering of the pressure after the first twelve to twenty-four hours and it is important not to precipitate this with hypotensive agents. The exact level at which hypotension should be treated must be individualized; if the patient presents no sign of clinical shock and is producing urine in adequate amounts, he does not need his blood pressure raised even though it may be 75 or 80 millimeters of mercury. If medication is required, I prefer metaraminol (Aramine) since it may be given intramuscularly or intravenously, and does not cause a slough if extravasated or with prolonged intravenous use. If levarterenol (Levophed) is used, 5 mg. of phentolamine (Regitine) added to each liter of solution will usually prevent slough. Digitalis has been used occasionally for shock in the absence of overt heart failure with good results.

Heart failure is usually left ventricular, and manifested by diastolic gallop rhythm and rales, and is an indication for digitalization. A few basal rales are frequently asymptomatic and disappear with rest or with an oral diuretic. Acute pulmonary edema, however, requires immediate and vigorous treatment with narcotics, oxygen, rotating venous tourniquets, intravenous digitalization, intramuscular diuretics, and aminophylline.

Arrhythmias

Arrhythmias may be caused by or may initiate alterations of the hemodynamics, particularly hypotension. Restoration of blood pressure often terminates arrhythmias associated with hypotension, or potentiates the actions of antiarrhythmic drugs. If any of the following arrhythmias are due to drug intoxication, stop the drug. In case of excessive digitalis, give slowly intravenous potassium chloride, 40 to 60 mEq. in 500 cc. of 5 per cent dextrose solution. If due to quinidine or procainamide hydrochloride (Pronestyl) overdosage, give intravenous molar lactate, 20 to 100 cc., or 10 to 20 units of crystalline zinc insulin and 50 to 100 cc. of 50 per cent dextrose solution. Control hypotension with vasopressors.

Premature ventricular beats are serious, especially if not present prior to infarction, and may precede ventricular standstill, tachycardia or fibrillation. They should be treated vigorously with quinidine sulfate 0.2 to 0.4 Gm. (3 to 6 grains) four to five times a day, or procainamide hydrochloride 250 to 750 mg. orally every two to four hours. After the ventricular beats are under control, continue the medication four times a day. If the patient is nauseated, vomiting or has gastrointestinal symptoms, the intravenous or intramuscular routes must be used.

Atrial premature beats are less serious, and usually respond to quinidine or full digitalization.

Supraventricular tachycardia may usually be terminated by unilateral carotid sinus pressure fortified by breath-holding and sedation. If these measures fail, partial digitalization (lanatoside C [Cedilanid] 0.8 to 1.2 mg. intravenously) will usually potentiate the carotid sinus reflex within 10 to 20 minutes. I have occasionally used "cardioversion" in resistant cases. Vagal stimulating maneuvers are potentially dangerous in acute infarction, and should be performed only under electrocardiographic monitoring.

Atrial fibrillation and atrial flutter may produce a rapid ventricular rate which increases coronary insufficiency and may cause death. Intravenous or intramuscular digitalization is therefore indicated. If these arrhythmias persist, I attempt conversion with quinidine or lanatoside C in the recovery or convalescent periods, but not during

the acute illness as long as the ventricular rate is controlled.

Paroxysmal ventricular tachycardia is even more ominous, but usually responds to oral or intramuscular quinidine every two to three hours for four doses, or to lanatoside C orally or parenterally every four to six hours. If the ventricular tachycardia persists, quinidine or lanatoside C should be given slowly intravenously with electrocardiographic monitoring. Recently I have used intravenous lidocaine (Xylocaine) with good results and no hypotension. Quinidine-induced or lanatoside C-induced hypotension is controlled with vasopressors. In refractory cases intravenous atropine sulfate (1 to 2 mg.) may be effective, but "cardioversion" is becoming the treatment of choice.

Ventricular fibrillation is often sudden. If it is diagnosed immediately, closed chest cardiac massage should be started at once, and then followed by external countershock, unless the patient has been in chronic heart failure or has other evidence of no cardiac reserve. I have not used open chest massage in any acute myocardial infarction.

First degree heart block requires no treatment, but second and third degree atrioventricular blocks merit immediate attention because they often precede cardiac arrest. Atropine sulfate, 0.5 to 2.0 mg. intravenously, will improve some cases. For complete block with Stokes-Adams syncopal attacks, I use intravenous or intramuscular isoproterenol (Isuprel) hydrochloride or epinephrine. After the atrioventricular block is stabilized, sublingual isoproterenol or oral ephedrine sulfate may prevent further attacks. If the attacks are not controlled with medication, the use of an internal pacemaker threaded intravenously into the heart should be considered. I have not had personal experience with this technique, but encouraging reports are being published.

In cardiac arrest, assisted respiration and closed chest massage, followed by intracardiac epinephrine are indicated. Prolonged precordial or intracardiac electric stimulation may be necessary. Molar lactate solution, 20 to 250 cc. intravenously, is given in the presence of acidosis or hyperpotassemia. Procainamide hydrochloride, quinidine and potassium salts are contraindicated.

Conclusion

Fortunately, serious arrhythmias are not frequent, but they demand immediate diagnosis and treatment. With the advent of constant electrocardiographic monitoring, and increasing experience with the direct current "Cardioverter," I expect additional improvement in the mortality rate of this unpredictable disease.

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Editor's Note

For the first time an issue of The Journal of the Florida Medical Association presents a symposium upon a specific disease. The contributing authors were chosen by guest editor William M. Straight, M.D., of Miami, because of their especial interest in varying aspects of myocardial infarction. Each was limited in the length and detail of his discussion in order to present the broadest possible coverage in the space available. Dr. Straight and the contributing authors have fulfilled a difficult assignment with distinction. It has been a pleasure to work with them.

Other specialty societies have been invited to present similar discussions to follow in later issues of The Journal.

T. M.

Special Article

Serum Enzymes in the Detection of Myocardial Infarction

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The number and variety of serum enzyme determinations as diagnostic and prognostic aids in patients with myocardial infarction may justifiably perplex the physician at the bedside. A brief review reflecting the evolution and direction or trends of such measurements should provide a foundation and perspective for selection and interpretation of these clinical enzyme assays. Specificity and sensitivity as well as accuracy and precision are prerequisites in all measurements that serve as useful guidelines in clinical pathologic correlations.

Discussion

Some 10 years have elapsed since LaDue[1] reported transient elevations of the serum glutamic oxaloacetic transaminase (SGOT) following myocardial infarction. Since then numerous enzyme alterations have been described, but the majority of these enzyme alterations are of dubious clinical importance either because of the lack of specificity or because of their transient alterations.

Serum aldolase, an enzyme of the glycolytic system catalyzing the splitting of fructose 1, 6-diphosphate to D-glyceraldehyde 3-phosphate and dihydroxyacetone phosphate, shows significant elevation in the majority of patients some two to eight days after the onset of infarction.[2] More impressive increases are generally seen in muscular disorders, particularly progressive muscular dystrophy, and in hepatocellular degeneration and/or necrosis. In the diagnosis of myocardial infarction, it apparently has no advantage over the more commonly used enzyme. Phosphohexoseisomerase, another enzyme associated with the glycolytic system converting glucose 6-phosphate into fructose 6-phosphate, also shows a transient increase in serum activity after myocardial infarction,[3] but again appears to be nonspecific, showing elevations in liver disease and in muscular dystrophies.

Elevation in the serum copper,[4] which is normally remarkably constant, occurs in acute myocardial infarcts. This increase tends to occur late (one to five days) and remains elevated some 10 to 15 days. Since the serum copper level primarily reflects ceruloplasmin, which has high oxidase activity, determination of the serum oxidase activity often shows an extended elevation after myocardial infarction.[5]

The enzyme systems most commonly utilized in the diagnosis of acute myocardial infarction have been the transaminases and the dehydrogenases. The SGOT has been most widely used since it has a very high enzyme activity in cardiac muscle and offers a greater degree of specificity than the dehydrogenases. The SGOT usually rises within six to 12 hours and persists for a variable length of time, usually three to five days. The most impressive limitation in the use of the SGOT is its very transient nature, which often is not fully appreciated. For instance, while the majority (90 per cent) of patients with acute myocardial infarcts show elevations of the SGOT, a significant number show return to normal levels by the second day after infarction, and in some studies the majority of patients show return to normal by the third day.[6] Interpretation then of a single normal SGOT determination can be misleading and adequate sampling in a suspected case of acute myocardial infarction usually requires serial determinations. Another limitation to the SGOT is its failure to be elevated in small transmural or sub-

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endocardial infarcts. Furthermore a single determination, although within normal ranges of the population, might be significant in relation to the patient's own normal level. Acute myocardial infarcts complicated by congestive heart failure may produce elevations of the SGOT related to central necrosis of the liver. The serum glutamic pyruvate transaminase (SGPT) while present in cardiac muscle shows only transient rises after acute myocardial infarction even of a massive nature,[7] and can be used to help distinguish elevations of SGOT primarily related to heart failure, that is, central necrosis of the liver rather than cardiac muscle necrosis. A practical disadvantage insofar as the clinical pathology laboratory is concerned is the difficulty and complexity of the transaminase determination relative to the more simple dehydrogenase assays.

The dehydrogenases comprise a large group of enzymes of the glycolytic and tricarboxylic acid cycles which catalyze oxidation-reduction reactions in the presence of a coenzyme nicotinamide dinucleotide (NAD or NADP) which serves as a hydrogen donor or receptor. Those known to be of value at present in the diagnosis of acute myocardial infarction are the lactate, malate, and isocitric dehydrogenases.

The isocitric dehydrogenase (ICD) is used predominantly in hepatocellular degenerative diseases[6] and while elevations are seen in acute myocardial infarcts, they are of a very transient nature and may be related to concurrent liver damage.[8] The malate dehydrogenase[9] likewise shows such a transient elevation that its use in the diagnosis of acute myocardial infarction is of dubious value.

The lactate dehydrogenase (LDH) system catalyzing the reversible conversion of pyruvate to lactate at pH 7.4 and lactate to pyruvate at pH 9-10 is probably of much more practical value. Its major advantage over the transaminase systems is that it shows significant and prolonged elevation after acute myocardial infarcts, with persistence for some seven to 12 days.[6] In some cases, elevations of the LDH occur very early after infarction, before a rise in SGOT. We have seen elevations within four hours after the onset of pain. The major limitation of the LDH is simply due to its ubiquitous distribution, that is, being present in all tissues, it shows elevation with diseases of different organ systems. By itself then, while it is universally elevated in serum of patients with myocardial infarcts and indeed the diagnosis of acute myocardial infarction is somewhat tenuous without a rise in serum LDH activity, it is relatively nonspecific.

Total serum LDH activity has been shown to consist of several different components differing from each other serologically, chemically, and electrophoretically. These varying components which differ electrophoretically have been termed isoenzymes or isozymes,[10] since they catalyze the same reaction or utilize a common substate. Five electrophoretically different components for lactic dehydrogenase of human blood have been separated and categorized as LDH_1, LDH_2, LDH_3, LDH_4, LDH_5.[11] LDH_1 corresponds to the slow-moving gamma components of serum proteins; whereas, LDH_4 and LDH_5 correspond to that component moving with the $alpha_1$ and $alpha_2$ globulins respectively. These isozymes have a characteristic distribution in human tissues and show individual quantitative isozyme patterns.[12] For instance, LDH activity associated with cardiac muscle has a predominance of LDH_5 and LDH_4, that is, fast-moving components of the $alpha_1$ and $alpha_2$ globulins; whereas, liver and skeletal muscle have predominance of the slower-moving components associated with the gamma fraction LDH_1 By the use of isozyme activities, a great deal of organ specificity can be achieved in the dehydrogenase systems.

The techniques for separating and determining lactic acid dehydrogenase isozymes have included starch gel,[12] agar gel,[13,14] and column chromotography[15] and then the demonstration of activity after elution or in situ by any one of the colorimetric or spectrophotometric techniques. These techniques are time-consuming, laborious, and often require equipment not ordinarily available. They have, however, afforded means by which the isozymes can be separated and then some attempt made to differentiate the isozymes by techniques which are simpler and within the scope of the average clinical pathology service.

It has been shown that the isozymes have immunochemical differences and the antibodies can be made against the various isozyme components.[16] Various chemicals can be shown to have differing rates of inhibition on the various isozymes.[17] Neither of these techniques, however, has provided a simple and practical means of differentiation. Lactate dehydrogenase utilizes as its coenzyme, NAD. The various isozymes can be shown to have varying abilities to utilize coenzymes that have had substitutions made on the

nicotinamide ring.[18] To date, these applications are not practical in a service-oriented laboratory. The most useful and practical methods to date have been in the utilization of substrate analogs and heat stabilities. By utilizing different substrate analogs, that is, different alpha-keto acids, the fast-moving and slow-moving components can be distinguished. For instance, the isozyme of cardiac muscle, that is, the fast-moving component, LDH_5, has a greater ability to utilize 2-hydroxybutyrate; whereas, the isozyme of skeletal muscle and liver has almost no ability to utilize this particular substrate.[19] The serum hydroxybutyrate dehydrogenase, for example, is not a new enzyme, but merely the same enzyme utilizing a different substrate in an attempt to define the faster-moving LDH_5 component. Since the activity with hydroxybutyrate is never as great as the activity with lactate, the hydroxybutyrate to lactate dehydrogenase ratio must be calculated. This method for determining the relative contribution of LDH_5 and LDH_4 to total serum LDH activity has been used extensively by the European investigators.

The LDH_5 of fast-moving component associated with cardiac muscle and erythrocytes is relatively heat-stable; whereas, the LDH_1 or slow-moving component associated with skeletal muscle and liver is relatively heat-labile.[20,21] By determining total serum activity and then simply incubating the serum at 65°C. for 30 minutes, the residual activity, that is, heat-stable activity, can be expressed as percentage of total LDH activity.[20] Serum from patients with acute myocardial infarcts and homogenates of cardiac muscle show percentages of activity after incubation, that is, percentage heat-stable greater than 40 per cent and often as high as 90 per cent. The activity after incubation, that is, percentage heat-stable, associated with liver extract or in patients with liver disease, for example, viral hepatitis, is under 40 per cent and usually in the range of 10 to 20 per cent. While few clinical laboratories are equipped to do column chromotography or starch gel electrophoresis, and may be reluctant to set up a new enzyme system with one of the substrate analogs, certainly the use of the heat-stable LDH activity requiring only the use of a water bath is within the reach of the vast majority of laboratory procedures.

We have had very promising experience in utilizing the percentage heat-stable LDH activity in the diagnosis of acute myocardial infarction. Total serum LDH activity elevations associated with numerous disease entities ranging with carcinoma, pulmonary infarction, pneumonia, cancer with and without metastases to the liver and or bones, muscular dystrophy, postoperatively and in lymphomas and leukemias have all shown percentages of heat-stable activity below 40 per cent and in the vast majority of instances less than 30 per cent. Of seven acute myocardial infarcts, either documented by electrocardiogram or autopsy, all have shown elevated total serum LDH activities and all have shown percentages of heat-stable components greater than 40 per cent. Only one disease entity has been associated with a high percentage of heat-stable activity (65 per cent) and this was in a patient with acquired hemolytic anemia. Since erythrocytes are rich in LDH_4, which shows significant heat stability, confusion might arise in patients with hemolytic anemias or be due to in vitro hemolysis.

Summary

The most impressive limitation of the SGOT, namely, its transient nature, can be obviated by the use of lactate dehydrogenase assay. The relative nonspecificity of the LDH presumably due to its ubiquitous distribution in tissues can be circumvented by determination of the isozyme content. The isozymes of the LDH have rather characteristic patterns in different tissues and provide a relatively easy method of obtaining organ specificity. Of the various techniques utilized, for separating and determining the isozyme activities, the only practical methods for use in clinical pathology have been the use of substrate analogs, for example, hydroxybutyrate, and the heat-stable determination. Of these two, the determination of the heat-stable LDH activity has provided a practical and reproducible method of determining the relative contribution of LDH_4 and LDH_5 isozyme to the total serum LDH activity. The utilization of the heat-stable lactate dehydrogenase can afford a degree of specificity coupled with sensitivity that makes the LDH activity assay extremely accurate in the diagnosis of acute myocardial infarction and provides a methodology certainly within the scope of a clinical pathology service now equipped to perform LDH activities either colorimetrically or spectrophotometrically.

References are available from the authors on request

President's Page

Controls - Drugs

Ever increasing controls are characteristic of the age in which we live. Because of a serious decline in individual discipline these controls are being applied by organized groups and government. Medicine is included in this trend of our time. We know the reasons behind these changes, but do we evaluate them honestly and try to profit by the knowledge gained?

Aiding and abetting welfare causes today are a few physicians who exploit those who pay the bills by over-prescribing drugs at exorbitant costs. Many of these are filled at pharmacies in which the doctor has a financial interest. Recently, its monthly drug bill was so frequently over the budgeted $600,000 that the Florida Department of Public Welfare consulted its medical advisory committee on the subject. Information submitted indicated that, in April, 35,691 welfare patients received 152,-053 prescriptions at a cost of $647,333.85 to the state and federal government. Such high costs resulted in the new control on all doctors and all welfare patients to the effect that no ambulatory welfare patient in Florida can obtain more than $40 worth of drugs in any 30 day period, except in acute circumstances when a supplemental request supplying information must be made. On the surface this is not a bad control. Ninety-odd per cent of ambulatory patients should not need more drugs than that in a month, but one Florida physician prescribed drugs costing $314 to one ambulatory patient in May and one prescribed $40 worth of vitamins in a similar period. It may be difficult to say there is anything dishonest in either of these cases, BUT anything which opens the door for a physician to have government dictate any part of his practice is unhealthy. We should know well that once controls are applied, they are easy to supplement and difficult to abolish.

Looking deeper into the background we find it to be a matter of House of Delegates record that three physicians were expelled from the Florida Medical Association because prolonged investigation and adequate hearing confirmed the prescribing of drugs in unnecessarily large amounts and varieties to welfare patients costing in excess of $13,000 monthly. The prescriptions were filled in the pharmacy of a hospital owned by these physicians. Court action reinstated their membership and the matter has been in litigation since that time. Recently, it was called to our attention that a similar group showed an increase of $7,000 in prescriptions filled in one month. This is under investigation. There may be no wrongdoing, but it reflects badly on physician ownership of pharmacies and hospitals when some of those with such relationship are chief offenders. The House of Delegates of the American Medical Association in 1963 said, "It cannot be considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of his patients." Let us keep it that way.

At the same convention the House of Delegates declared, "It is unethical for a physician to have a financial interest in a drug repackaging company—with the objective that physicians having a financial interest in the drug company will prescribe its drugs for the patient." A Senate subcommittee is investigating physician ownership of drug repackaging companies seemingly expecting to find that physicians are using such ownership to exploit patients by overprescribing and by raising the cost of the drugs. Exceptions are doubtless to be found, but the early hearings have not confirmed their suspicions. The American Medical Association and the Florida Medical Association are interested in physician activities which attempt to exploit patients. Wrongdoing was implied in statements made by the Senate committee and the American Medical Association, but exploitation of patients by Florida physicians interested in drug companies has not been brought to the attention of the Florida Medical Association.

As a group, physicians have pioneered innumerable measures in the past which have improved the health care of our people without regard to financial return. Physicians organized and directed many of our leading pharmaceutical companies. Many years ago it was said Medicine is the only profession that strives constantly to eliminate its reason for being. This still holds true. As the one group that has frequently provided its services to government as charity or at a financial loss, it is ironical that government consistently turns to medicine with an accusing eye when things go wrong.

When the $40 monthly limit was suggested by the Welfare Department, a representative of the pharmaceutical association stated it would increase administrative costs and the druggists would have to charge more for drugs. This emphasized a paradoxical approach to charity which has proved perplexing to some of us for years. No doubt many pharmacists do much for charity, but in Florida pharmacies are paid cost PLUS a minimum profit of 66 2/3 per cent for drugs for welfare patients. The profit increases up to 150 per cent or more as the total dosage decreases because more dispensing is necessary. Their billings and payments are made through the Florida Pharmaceutical Association at an additional percentile cost which totals approximately $200,000 annually. Yet it is the physician, usually charging such patients little or nothing, who is vilified for "overprescribing." Discriminatory practices such as these dim any satisfaction that may accompany charitable motives and encourage too many physicians to forget charity and charge more than this traffic can bear. No doubt reevaluations of standards are necessary from time to time, but if we are to keep our birthright of freedom in the practice of medicine, we must not surrender to such temptations.

Controls previously applied limit a welfare patient's prescriptions to one month's supply and prohibit the dispensing of bandages except with prescribed medications. Such rules may necessitate a patient seeing a doctor more frequently than necessary, or invite the undesirable practice of patients returning to pharmacists for renewal of prescriptions and the prescriptions being telephoned and mailed by the physician without seeing the patient for long periods. Undoubtedly, the one month limitation results in overmedication in many instances, but it is likely that willful overprescription on the part of the physician occurs rarely.

Actually, a physician should have just as much right as anyone to participate in American free enterprise by owning an interest in a hospital, a pharmacy or a drug or medical equipment firm as long as he does not exploit his patients or their benefactors. We physicians must prove that by the use of discipline—self discipline, and if necessary organized medical discipline—we can assure the public that there is no inherent danger of exploitation through physician ownership of anything and additional controls are not only unnecessary but are superfluous.





Excess Payments From Health Insurance

Should a patient be able to profit financially from a stay in a hospital or by receiving a doctor's services? This question is being raised with greater frequency since research studies indicate that 8 to 15 per cent of those who have prepayment insurance coverage of their hospital, medical, and surgical charges have one or more additional policy.

Because of this duplication of coverage, some commercial health insurance carriers are adding a "No Duplication" clause to many of their group contracts and to some of their direct pay contracts.

In one of Central Florida's leading hospitals, the total hospital charge for a particular admission was $976.50. The patient had one Blue Cross policy and two commercial health policies. The total health insurance payment was $1,568.00. The patient received from insuring agencies $592.00 in excess of the total hospital charges.

Similar cases are on record for coverage of medical and surgical charges where patients have received payment in excess of the total amount billed by the physician and surgeon. In recent months, the Blue Shield plan and its companion Blue Cross plan have given serious consideration to including a nonduplication clause in the health insurance contracts made available to groups and to direct pay subscribers of the plan. If such a clause were included in contracts, it would mean that the Blue plans and any commercial insurance companies involved in covering these subscribers would pay benefits totaling up to the full amount billed for services but would not allow the subscriber, ill as he may be, to make money from prepaid insurance.

If this nonduplication clause were to be included in health care contracts, it would undoubtedly lead to a reduction in the rates charged for such coverage. The rate should fall because (1) duplicate administration would occur less frequently and (2) three or four companies would not pay their maximum on one operation. Look at an example. Blue Shield, Company A and Company B have coverage on you. You have your appendix removed. You collect from Blue Shield, and A, and B. Three groups therefore pay for removal of the same appendix. At the end of the year, the actuaries of all three organizations set up the cost of their polices based on how much usage they had experienced in the past year. Your appendectomy boosts all three firms' figures for the number of operations performed that year. This in turn increases the cost of the policy. What should happen is that the primary insuror (the one who insured the breadwinner) would pay its full fee for the appendectomy and then if there is a remaining unpaid bill, the other two companies divide the cost evenly. The patient gets his bill paid and the companies have fulfilled their obligation. The use of health insurance to pay for unemployment, maid service, or just plain profit will produce overpriced health insurance.

If the Blue plans and the commercial health insurance plans did adopt this nonduplication clause, they would be following a pattern already set in fire insurance and in automobile insurance coverage.

Prepayment of health insurance cost has become an integral part of our American way of life. We have a responsibility to our patients to see that quality health care is provided as reasonably as possible so that our patients would not have to allocate too large a portion of their income on expenditures for this care. These expenditures, of course, include premium payments for health insurance.

We are in an era of rapidly rising health costs, and therefore we must urge our patients to purchase full but not excessive coverage. This would mean, in effect, giving our wholehearted cooperation to all health insurance carriers as they make an effort to eliminate excess payments for health care in order to reduce the cost of their

insurance. You and I, as members of the medical profession, know that three problems face us with greater frequency. These problems include (1) a sufficient number of hospital beds; (2) efficient utilization of these beds, and (3) the most efficient expenditure of funds for every phase of health care. It is up to us to see that our patients are able to live within a predictable budget for their health care cost. A nonduplication clause, providing coverage for no more than the full charges, is one way of preserving private medicine in this nation. In the months ahead, as you hear this nonduplication clause being discussed in greater frequency, I hope you will make an effort to be acquainted with the philosophy behind it—adequate coverage but not surplus coverage. I feel sure that representatives of the various prepayment agencies stand ready to discuss it with you should you call on them.

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The Case for Cadaver Blood

In June of last year at the University of Mississippi Medical Center in Jackson, in a brilliant and pioneering operation, the left lung was removed from a cadaver and given to a 56 year old man who had an epidermoid bronchogenic carcinoma of his own lung.

In September in a Boston hospital, the liver was taken from Patrolman Edward C. Callahan who had been shot and killed while trying to foil a hold-up in a suburban Boston supermarket. This liver was then transplanted into the body of Joseph J. Bingel who badly needed a normal liver in order to continue living.

One month later, in Colorado, Housewife Jeanine Good fellow who had advanced carcinoma of her own liver received in transplant the normal liver of a man who had died of accidental gunshot wounds.

In a New York hospital, a white boy, not quite two, was given a kidney transplanted from a 13 year old Negro lad who had died of a brain tumor.

At Tulane University in New Orleans, a housewife whose own kidneys were not functioning was given a pair of kidneys from a 25 pound rhesus monkey.

The eminent surgeon, Dr. DeBakey, has replaced the damaged valve of a heart with an artificial caged-ball valve.

On January 23 of this year, a University of Mississippi team replaced a human heart with a heart from a large chimpanzee.

But, going backwards in time, it is learned that people have been donating for some years their eyes to eye banks after dying. In fact, some people consider it quite in fashion to do so and donees quite eagerly accept parts of these eyes without questioning whether the donor was alive or dead. There are bone banks and cartilage banks which accept donations from dead people. Before the use of plastics in surgery, sections of aorta were freely taken from cadavers to repair aortic aneurysms.

In view of the fact that patients have accepted lungs, livers, kidneys, and other parts of the human body from cadavers and even from a 25 pound monkey and a chimpanzee, one cannot help questioning why people are so squeamish about taking cadaver blood into their systems.

Over 30 years ago, on March 23, 1930, at the Sklifosovsky Institute in Moscow, Dr Serge Yudin performed the first cadaver blood transfusion. Since that historic day, the Institute, which is the central emergency hospital in Moscow, has used cadaver blood in more than 30,000 transfusions. It has been reported that last year, in Moscow alone, more than 3,000 transfusions using cadaver blood were given.

The greatest advantage of all in using such blood is that it is both plentiful and inexpensive. Whereas only one pint of blood at a time can be obtained from a live donor, anywhere from four to eight pints may be drained from a cadaver, depending upon its size. Although our present blood supplies may appear to be sufficient to a few authorities, they will be as a few drops in the proverbial bucket in times of train wrecks with extensive injuries, in great fires and earthquakes, and especially in an atomic holocaust where the injured and dying may number in the hundreds of thousands. Blood, it must always be remembered, is life.

The second advantage is that since cadaver blood is rich in fibrinolysins and will not clot,

anticoagulants such as are used in processing blood from live donors need not be employed. This absence of citrates reduces the number of transfusion reactions which may normally occur.

A third advantage is that a complete pathologicoanatomic study of the cadaver can be performed to provide definite information concerning the presence of syphilis, cancer, bacterial infection, or any of the other conditions which would make the blood unsuitable for use. Today, in the present situation, the word of the live donor, along with a few tests, must be relied upon. As Professor Tarasov, Director of the Sklifosovsky Institute, told a visiting American physician, "We really know much more about our donors than you do about yours."

The last advantage is that a patient who needs a large quantity of blood either during an operation or in extensive blood loss from injury or disease, can get six or eight pints all from one source rather than from six or eight different sources with perhaps six or eight different blood subtypes. In this manner, the incidence of transfusion reactions will be lessened.

As the Russians explain the procedure, the use of cadaver blood is contingent upon certain conditions, most important of which is that the decedent must have died a "sudden death," such as a heart attack or a "stroke." Cases of "sudden death" in which there have occurred blunt trauma, crushing of tissues, large open wounds, lacerations, abrasions, infection, or chronic disease are excluded because of fear of incipient infection.

Blood must be removed from the cadaver within six hours of death or certain undesirable changes will occur in the blood.

When a likely prospect appears at the Institute, a special team of two people collects the blood under the same aseptic conditions used on a living donor. The blood is then typed and stored pending microscopic tests and an autopsy report. Once it is definitely established that no disease is present, the blood is released for general use.

Although the complete operation is simple and routine, it is resisted here in the United States. Some critics point out that certain family and legal problems would complicate the procedure. This is not necessarily the case. The donor himself could expedite matters and avoid delays were he to carry on his person at all times, along with his identification papers, a brief statement authorizing the nearest blood bank to make use of his blood. This would be signed jointly, not only by the person who actually has no legal jurisdiction over his remains, but by his next-of-kin who most definitely does have a say and who would add a telephone number so that he could be contacted immediately. At the moment, there is legislation being proposed in Massachusetts so that people can will their remains to proper institutions with a minimum of legal red tape.

Other critics think that there is no need for such blood since American blood banks have an ample stock of blood. This opinion is not a fact today when large amounts of blood are being used in every hospital in the land, not only for direct transfusion but also for priming heart-lung machine oxygenators. Experts agree that were a nuclear attack to be mounted against the United States, our present blood supply would be woefully inadequate.

Still other critics have used the vague word "impracticable," when they probably meant to use the word "squeamish."

As recently as June 1963 cadaver blood has been called safe to use by an investigating group from Bowman Gray School of Medicine. As a matter of fact, patients have already been given transfusions with cadaver blood in Pontiac, Mich., and have had practically no reactions whatsoever.

What with the abrupt sociological upheavals which have appeared on the American scene within the past decade, we predict that the wholesale use of cadaver blood will be commonplace in the foreseeable future. We hope that in some small measure this article will hasten the day.

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George Did It

The J. Hillis Miller Health Center is flourishing. Most Florida doctors are probably not aware of the fact that the Hospital and Clinics of the University of Florida College of Medicine now have a full supply of patients and operate at near capacity all the time.

The students and the graduate training program are reported to have entirely adequate material for study. This is a real credit to the staff of the hospital and the medical school, and in particular to Dean George T. Harrell, who began "his" project just 10 years ago.

Surely one major reason for this manifest success is the policy with regard to referral of patients. Despite pressures to do otherwise, Dean Harrell has steadfastly held out that patients should be admitted only by referral of an outside physician. He has emphasized that this is not a chronic disease center for long time treatment, and that for consistent proper care of the patients, there must be someone to refer the patient back to after the studies and work-up at the Medical Center.

The net effect of this policy has been a very good influence on the house staff to maintain adequate liaison with referring physicians.

Patients return home from the Medical Center consistently happy with their treatment there, and with good reassurance from the Health Center doctors as to the qualifications of their home doctors.

Of course, a good many patients are sent to the Medical Center with little more than a brief phone call or a "buck slip," but many others should be accompanied by the volume of accurate information that the home physician can supply. This gives a head start for the Health Center physicians and provides "more for the money (no small sum)" for the patient.

Healthy criticism of various aspects of the medical school have been heard and will continue to be heard, but Florida and Dr. Harrell have a right to be proud.

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Lake Wales

Florida-Cornell Automotive Crash Injury Research

Commencing last April 1, physicians in selected areas of Florida were and will be asked to participate in the automobile crash injury studies of the Cornell Aeronautical Laboratory, Inc. (Cornell University). Since its inception, the purpose of this research has been to obtain reliable data on the specific causes of injury to occupants of cars involved in accidents, rather than on the causes of the accidents themselves.

Information from the interstate Automobile Crash Injury Research (ACIR) program has served as a basis for the designing of passenger protection devices such as seat belts, improved door latches, energy-absorbing steering wheels, padding, and so on, with which automobile manufacturers began equipping their cars about 1955. Now, one of the purposes of the program is to collect data for use in evaluating the effectiveness of those recently adopted safety devices, as well as in showing the need for additional protection.

Trauma produced in highway accidents is a "disease" endemic to the Western Hemisphere during the twentieth century just as bubonic plague, typhoid fever and malaria were seemingly ineradicable during the previous eras.

The Cornell studies employ the epidemiologic approach, and Florida is the twenty-seventh state in which the State Medical Association, the State Board of Health, the State Hospital Association, and the State Highway Patrol have agreed to cooperate. The other states are Indiana, North Carolina, Maryland, Connecticut, Virginia, Minnesota, Arizona, Vermont, Texas, California, Pennsylvania, Georgia, New York, Michigan, Colorado, Oregon, Ohio, Illinois, New Mexico, South Carolina, Wisconsin, Iowa, North Dakota, Kentucky, Oklahoma, and Mississippi.

Accident investigators and members of the medical profession are contributing valuable data from this "laboratory of the highways" to the ACIR project located at the Cornell Aeronautical Laboratory, Inc. of Cornell University, in Buffalo, N. Y., where a standard technique of evaluation and analysis is employed to identify the characteristics of the environment producing trauma. The Cornell ACIR studies are sponsored by the United States Public Health Service and by the Automobile Manufacturers Association.

Thus far, the Cornell studies have shown that these safety devices are effective in preventing or reducing the severity of injury. In the injury studies conducted on crashes involving the newer cars, it has been found that the incidence of door-openings during accidents has been reduced by one third. Door latches of a greatly improved design have been incorporated in the 1963 models of two of the major car manufacturers and it is expected that these modified components will further reduce the frequency of door-openings.

As a result of these design modifications, it has been found that the frequency of passenger ejection is down about 40 per cent, and the serious

or fatal injuries have declined about 12 per cent. Yet, door latches have not been made crash-proof, and if they could be so designed to control the ejection problem, the Cornell authorities are convinced that 5,500 additional lives could be saved each year.

When in use during an accident collision, it is reliably estimated that seat belts account for a 35 per cent reduction in the risk of major or fatal injury.

During the tenure of the four and one-half year study in Florida, doctors are asked to provide medical information only during the six month period in which their county is represented in the sampling area. On an average there are eight counties included in any one period. Counties included during the first sampling period are: Escambia, Santa Rosa, Okaloosa, Walton, Holmes, Washington, Bay, Gulf, Calhoun, and Jackson.

When one or more occupants in a recent model passenger car (one of the last four year models) have been injured, the state trooper assigned to investigate the accident has two extra tasks to perform:

1. To take photographs of the damaged portions of the car and provide certain information with respect to the association of injury to car structure.

2. To deliver the Cornell medical report form, one for each injured person, to the hospital emergency room or doctor's office where the injured were taken (or to the county coroner for passengers killed in the crash).

The hospital employees give the form to the attending physician. When it has been filled in, it is forwarded by the hospital to the State Board of Health.

The physician will find that the form which he is asked to complete is a brief one, and since it is anticipated that reports will be sought on no more than four injured persons per day in the average eight county study area, the likelihood is small that any particular doctor will need to report on more than four or five occasions during the six month period.

Dr. George McCoy, Director, Accident Prevention Division of the Florida State Board of Health, will coordinate the medical aspects of the program. His office will receive the reports from the State Highway Patrol and from the doctors (in most instances, through the hospitals where the patient had been cared for) and will forward them to Cornell.

Physicians are urgently requested to participate in this effort, for it is aimed at attacking one of the nation's foremost problems. Unless the injuries of each person injured or killed in a qualified passenger car accident within the sampling area are carefully recorded, the effectiveness of the study and the value of the data produced will be seriously reduced. All data received by ACIR are treated as privileged communication.

Francis T. Holland, M.D., Chairman
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Florida State Department of Public Safety

News

The annual fall meeting of the Florida Pediatric Society is being held at the Colony Beach Resort at Sarasota on November 12-14, according to announcement by Dr. Oliver F. Deen Jr., of Tampa, secretary. The general subject is "All About Viruses" and speakers include Dr. James D. Connor of Miami; Dr. Saul Krugman of New York City; Dr. Frederick C. Robbins of Berkeley, Calif.; Dr. John B. Robbins of Gainesville, and Dr. Donald T. Quick of Tampa. The formal program begins at 9:00 o'clock each morning and is concluded at 1:00 p.m.

The North Florida Pathologists' Association will hold its regular meeting at 8:00 p.m., Thursday, September 17, in Schultz Auditorium, St. Vincent's Hospital, Jacksonville. A slide seminar will be moderated by Dr. C. Merrill Whorton of Jacksonville. No session is planned for October because of the meetings of the College of American Pathologists and the American Society of Clinical Pathologists in Miami Beach.

A Cardiovascular Seminar presented by the University of Florida College of Medicine in

Gainesville has been scheduled for October 9-10 in Room M-112, Medical Sciences Building. The program has been approved by the Florida Medical Association and the Florida Academy of General Practice. The next postgraduate program will be a Seminar in Gastroenterology planned for January 14-16.

The Second National Congress on Mental Illness and Health sponsored by the American Medical Association will be held in Chicago on November 5-7.

The Southeastern States Cancer Seminar is scheduled for November 11-12 in Jacksonville at the Robert Meyer Hotel. Speakers include Drs. Richard G. Martin; Eleanor Montague; Mortimer B. Lipsett; Stephen S. Sternberg; John A. Campbell; Donald Paulson; Richard Goldstein; Harry Grabstald; James T. Grace, Hugh J. Davis, and S. N. Bhaskar, D.D.S.

The VIII International Congress on Diseases of the Chest will be held in Mexico City on October 11-15. Registration blanks may be obtained from the American College of Chest Physicians, 112 East Chestnut Street, Chicago 60611.

Part I of the Tenth Congress of the Pan-Pacific Surgical Association is scheduled for September 20-28, 1966, in Honolulu, Hawaii; Part II on September 28-October 10 in Japan and Hong Kong, and Part III on September 28-November 1 in Japan, Hong Kong, The Philippines, Thailand, India, Singapore, Australia and New Zealand.

A postgraduate course in "Modern Concepts of Nutrition and Heart Disease" is being presented on October 22-24 in the auditorium of Mound Park Hospital at St. Petersburg by the American Medical Association and the Mound Park Hospital Foundation. Joint sponsors are the Department of Medical Education of the Hospital and the American Academy of General Practice. A total of 18 credit hours in Category I will be allowed by the Academy.

Dr. D. Ralph Millard Jr. of Miami was designated as the official American Medical Association representative to the Second Latin American Congress of Plastic Surgery, Northern Zone, held in Caracas, Venezuela, August 9-14.

Meetings

September

Physicians' Seminar on Respiratory Disease, Third Annual, September 12-13, Cherry Plaza Hotel, Orlando

Sixth Annual Instructional Course in Surgery of the Hand, September 18-20, University of Miami School of Medicine, Jackson Memorial Hospital, Miami

Florida Orthopedic Society, Fall Meeting, September 25-27, International Inn, Tampa

Postgraduate Seminar of the Duval County Medical Society, September 26-27, Hotel Robert Meyer, Jacksonville

Twelfth Annual Diabetes Seminar, September 30-October 2, Balmoral Hotel, Miami Beach

October

Cardiovascular Seminar, October 9-10, Room M-112, Medical Sciences Building, University of Florida College of Medicine, Gainesville

"Modern Concepts of Nutrition and Heart Disease," October 22-24, Mound Park Hospital Auditorium, St. Petersburg

Florida Society of Anesthesiologists, October 10, Hotel Singapore, Miami Beach

Florida Academy of General Practice, Fifteenth Annual Scientific Assembly, October 29-November 1, Yankee Clipper Hotel, Fort Lauderdale

November

Southeastern States Cancer Seminar, November 11-12, Hotel Robert Meyer, Jacksonville

Florida Pediatric Society, Annual Fall Meeting, November 12-14, Colony Beach Resort, Sarasota

American Medical Association, Clinical Convention, November 29-December 2, Americana Hotel, Bal Harbour

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1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

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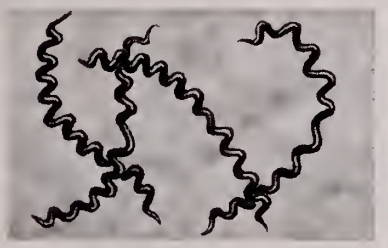
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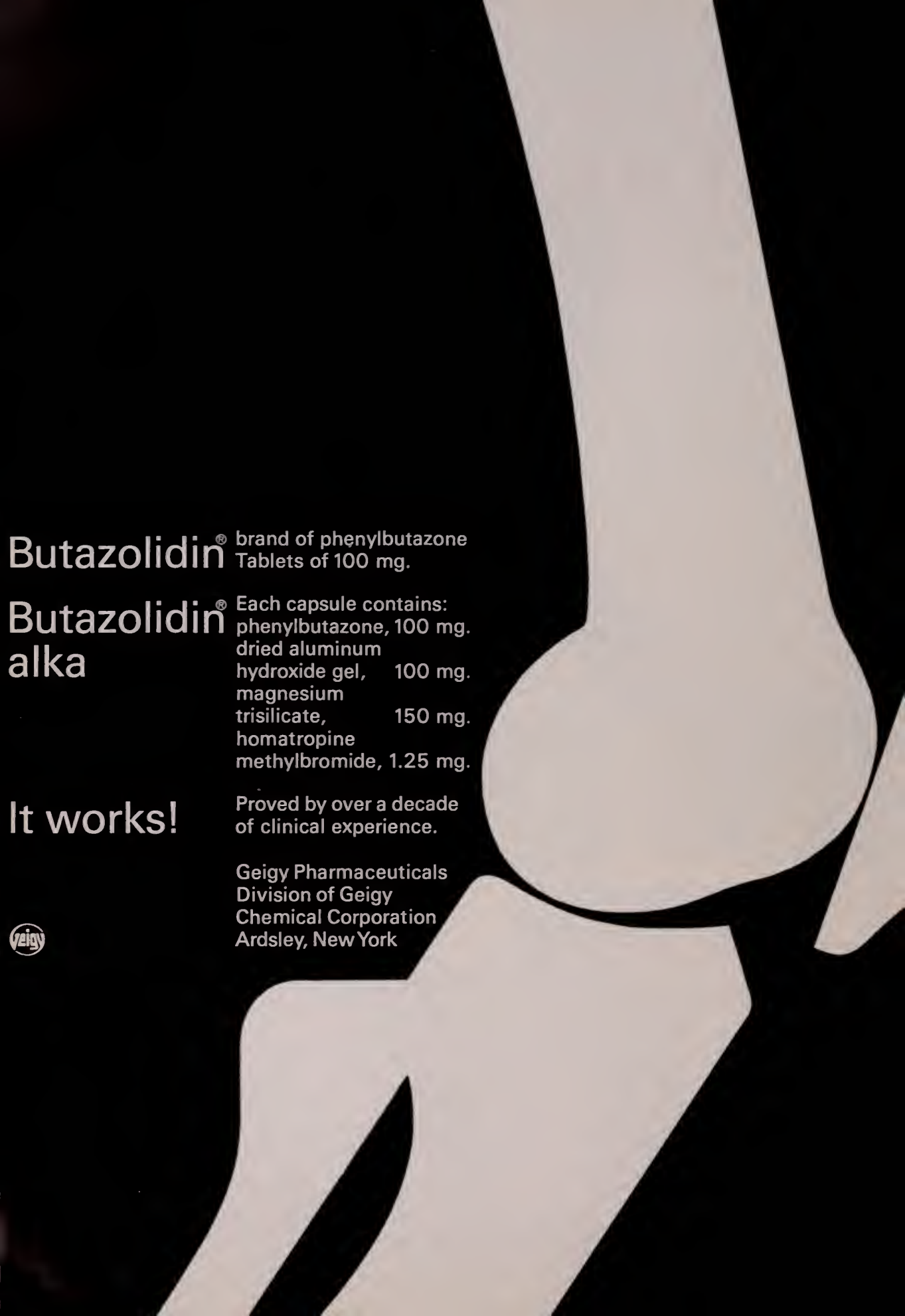
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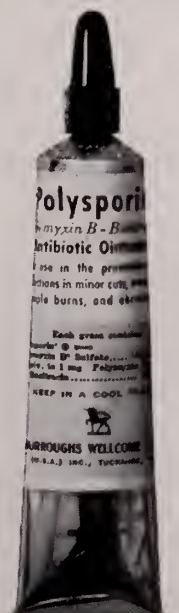
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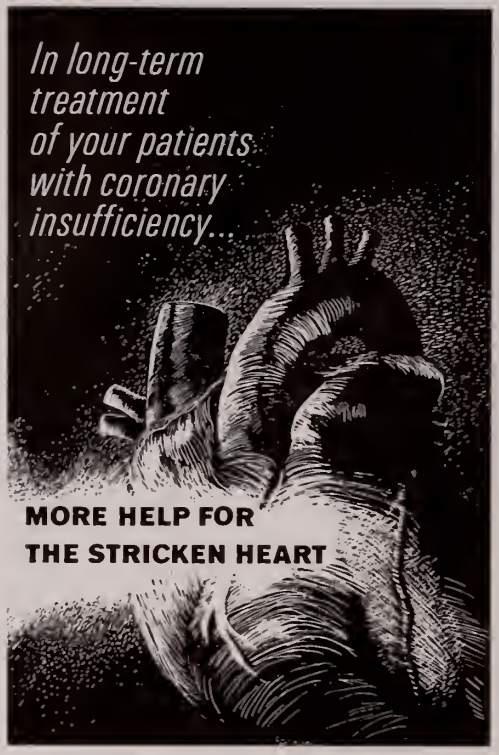
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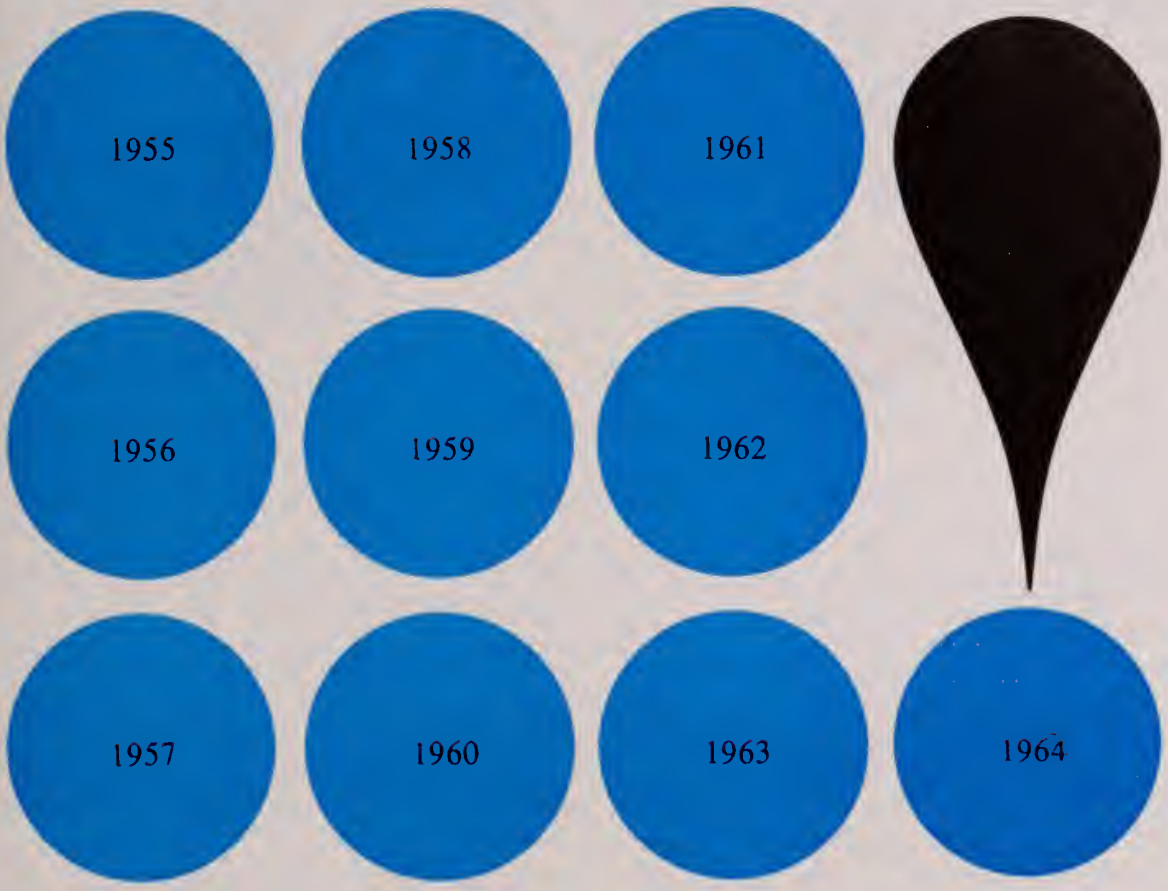
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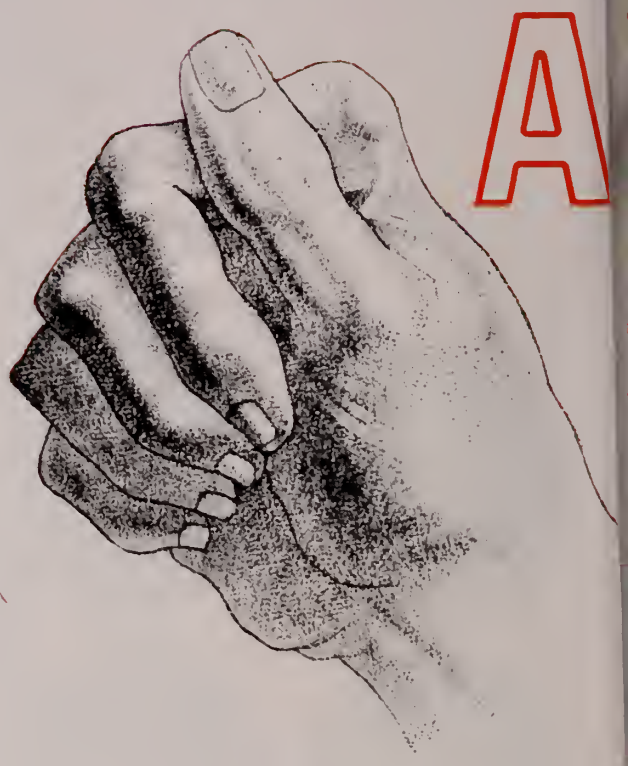
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*Cohen, et al: J.A.M.A., 165:225, 1957.

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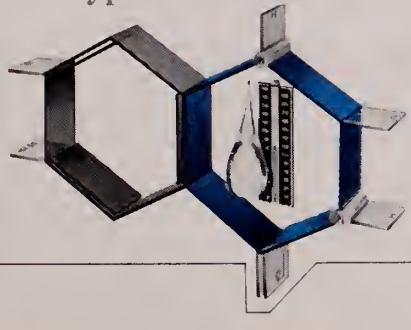
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CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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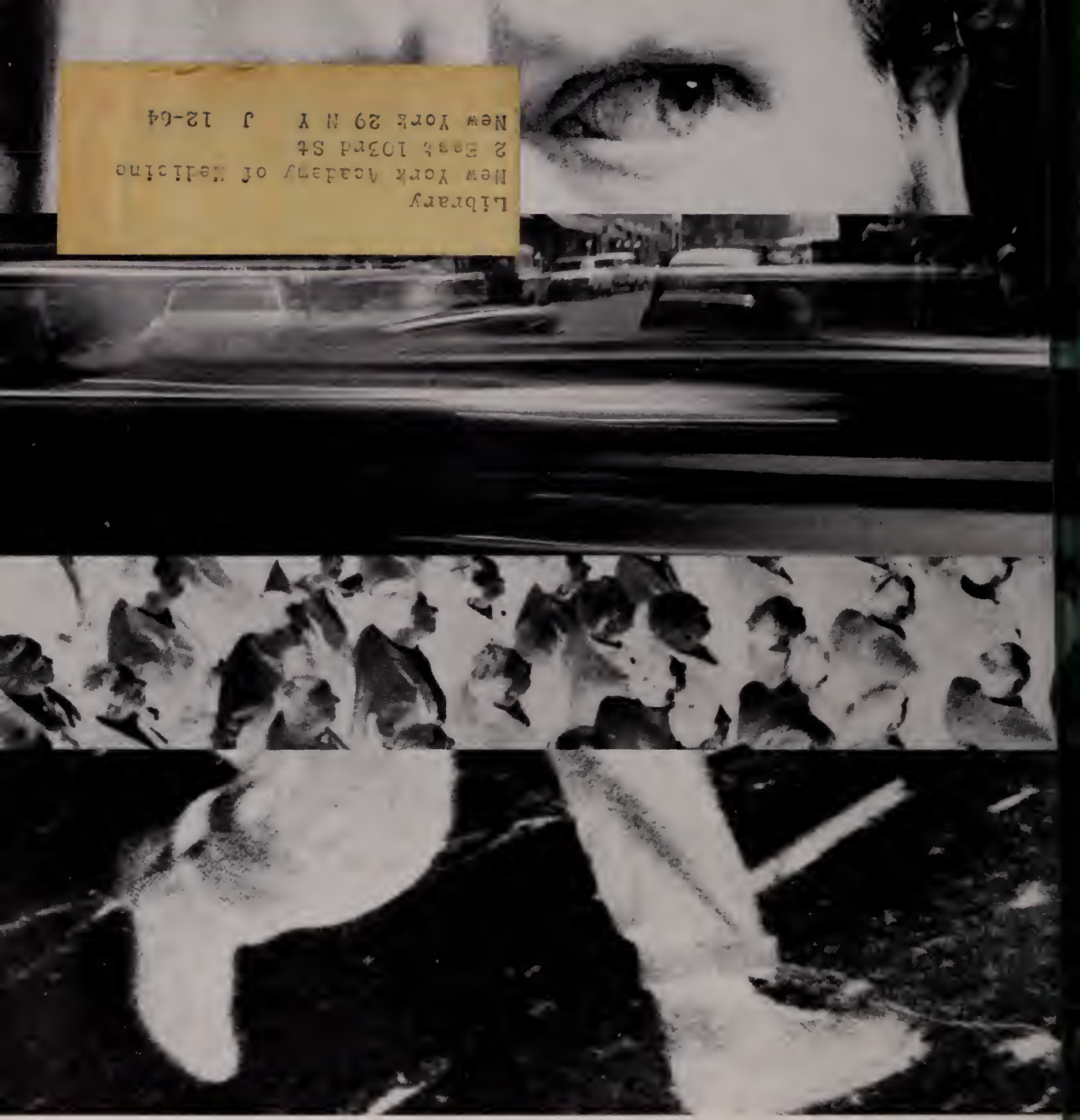
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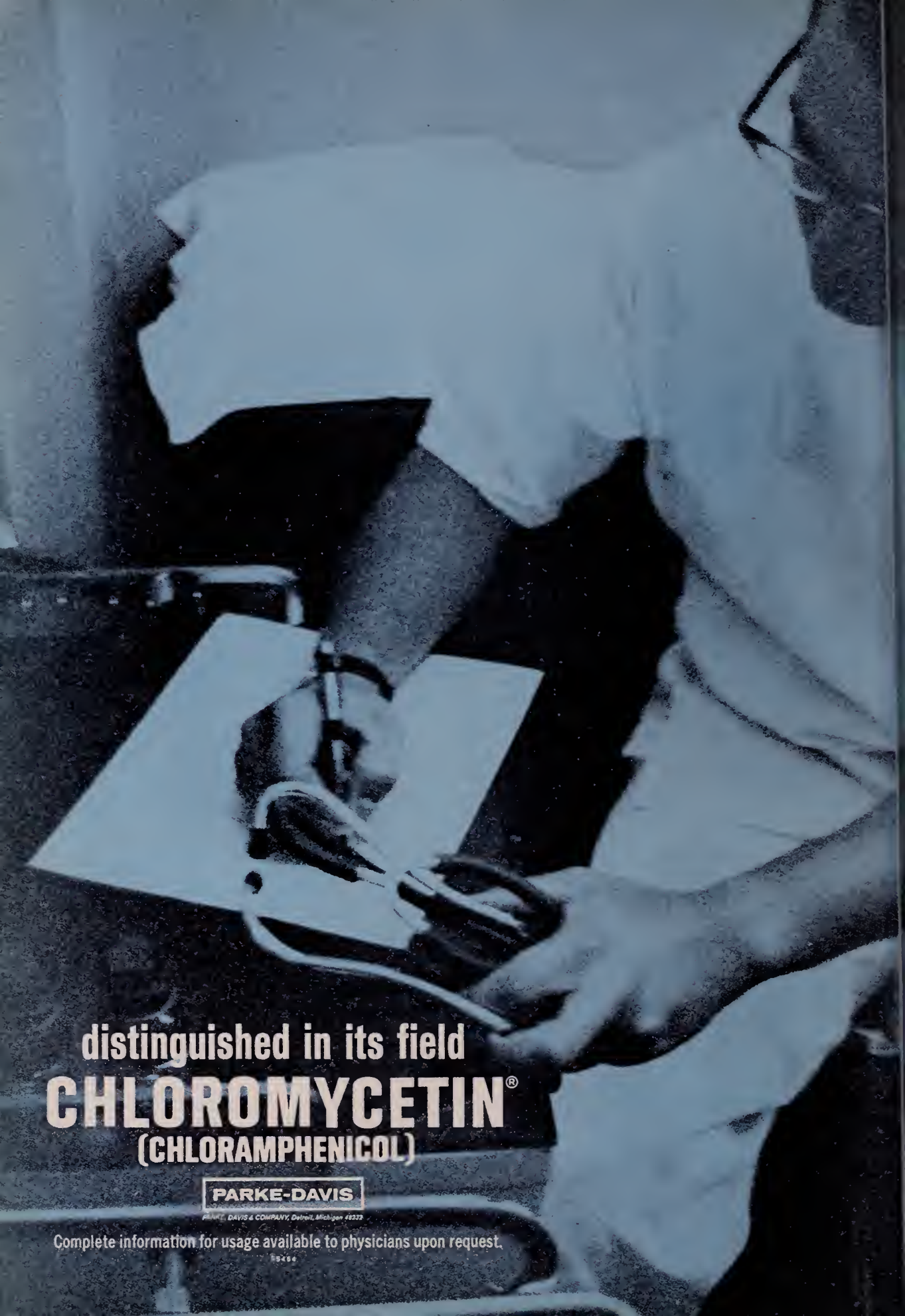
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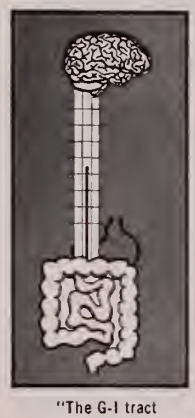
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Chattas, A. et al.: Antibiot. Med. 7:300, May, 1960.

Condition	No. of Patients	No. Cured with Signemycin
Eye, ear, nose, throat infections	368	343
Respiratory infections	369	346
Gastrointestinal infections	42	30
Skin and soft-tissue infections	38	37
Deep-seated or generalized infections	47	44
Various conditions	157	150
Totals	1,021	950 (93.0%)

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Brief Summary and Bibliography follow.

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Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

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Condition	No. of Patients	No. Cured with Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

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Electrical Hazards and Safeguards

Henry M. Stern, M.D.
LAKELAND

The fear of an anesthetic gas explosion caused by an electrostatic spark is in the mind of all personnel who use the operating room. The acceptance of the use of conductive footwear and the rigid observance of other precautionary measures well indicate the awareness of this danger. Though the danger of severe electrical shock is equally well known, protection against electrical shock is often neglected.

The fear of possible electrocution causes the professional electrician to wear shoes that are nonconductive. Much electrical equipment is used in the operating room, yet personnel are required to wear conductive shoes. Has the danger of severe electric shock been ignored? Is this an instance of conflicting safeguards where protection against one hazard has produced another?

This seeming paradox serves as a stimulus to a discussion of protection against the electrostatic spark phenomena and electrical shock in areas where explosive gases are present. It also serves to demonstrate that certain safeguard methods may be specific to a certain situation and may become a hazard if transposed to another situation. Conductive footwear is an example. A review of these safeguards gives an understanding of their need and means of operation. It also serves to help detect a hazardous situation caused by the absence or confusion of safeguards. The problem is no more complex than the safeguards of medical therapy in general.

The Electrostatic Spark

An electrostatic charge builds up on the surface of many different materials. If they are nonconductors of electricity, it remains on them. This charge results from friction with other materials or simple friction of the material upon itself. If two such objects at different electrostatic potential are brought close together, a spark discharge may occur. It will occur only when no electrical pathway of greater conductivity exists between the objects. When the humidity is above a certain level, the charge is equalized between objects by conduction through the small amount of moisture that condenses from the atmosphere.

An electrostatic charge of several thousand volts may build up on a person or object. At the instant of spark discharge the current flow may measure several hundred amperes. The duration of current flow is about one millionth of a second. This duration of flow is too brief to cause a burn or disturb physiology. The spark, however, is sufficient to ignite an explosion.

Since an electrostatic spark can occur only when a potential difference exists between objects, it can be eliminated by establishing an electrical conductor pathway between the objects. With a nonconductor such as a piece of silk, however, it is almost impossible to eliminate potential differences that may exist between layers and folds.

Electrical Shock

When a person becomes the connecting link between two points of different electrical potential, he serves as a conductor of electrical current. Whether this current flow is dangerous or not depends upon the amount of current, the duration of current flow, the surface area of contact, and the part of the body traversed. If the current is small enough, no effect is produced. Large currents produce varying degrees of electrical shock, burns and disturbed physiology, or death. A current of 10 milliamperes can be felt as a shock.

Currents of significantly greater amplitudes are used in electroconvulsive therapy and cardiac defibrillation. In these instances the current is time-controlled and is passed through a specific tissue area to produce a predetermined physiological response. The electrodes cover a large enough area to prevent burns.

When one touches two wires of a power circuit, an uncontrolled current traverses the body between the points of contact via the most direct route. In most power circuits one of the two wires is grounded at the power plant. Thus, touching only the ungrounded wire completes the circuit when any other portion of the body is making a ground contact. Unless the soles of the shoes are nonconductive, the feet make some degree of ground contact. Under such circumstances the amount of current which flows through the person is directly proportional to the conductivity of his shoes. The greater the current and the longer the contact the greater the danger.

To protect against this shock which involves a ground contact, the electrical resistance of the footwear must be so great that only a minute nondangerous amount of current will flow.

Any portion of the body may make a ground contact. It is for this reason that the electrician, in addition to wearing nonconductive shoes, is taught to work on "live" equipment with one hand only. He keeps the other hand well away from the field of activity.

Explosive Area Protection

In areas where explosive gases are in use, the hazard of electrostatic spark and electrical shock must be dealt with simultaneously. The electrostatic spark hazard must be eliminated by a method that equalizes the electrostatic charge between equipment and personnel. The electrical shock hazard must be eliminated by removal of the ground contact danger. The danger of sparks from power supplies, switches, and equipment is dealt with by the use of explosion-proof connectors and switches.

A conductive floor serves as the means of electrically connecting together persons and objects and equalizing the electrostatic charge between them. All apparatus must have metal contact to the floor. Personnel are connected to the floor through their conductive shoes. By ordinary electrical standards the actual conductivity of the floor is exceedingly low. Its resistance between two standard distance points, as well as its electrical resistance to ground, must exceed 25,000 ohms. This minimum is specified to protect against electrical shock by grounding.

As further protection against electrical shock and sparking due to insulation failure, the electrical power used in the operating room is isolated from the main power circuit by an isolation transformer. This precautionary measure means that the circuit is not grounded. It greatly reduces the shock hazard produced by conductive footwear, conductive flooring, and their inherent contact with ground. Though the personnel to ground contact should be extremely low, a structural defect causing a change in the conductivity of the floor is always possible. The importance of an ungrounded power circuit is so significant that an automatic alarm system to indicate its failure is mandatory. The alarm indicates that the circuit has become grounded.

As further protection against shock, the exposed non-current carrying metal parts of all electrical equipment are grounded. A separate insulated wire in the power cord is attached to the chassis of the apparatus and grounds to the building structure when the power cord is connected.

Thus, in areas where explosive gases are used, personnel and equipment are connected together via a conductive floor to equalize their electrostatic charges. The conductivity of the floor, as well as its conductivity to ground, is as low as possible to reduce the ground contact hazard to a minimum. The electrical power supply is isolated and ungrounded which reduces its potentialities of producing a shock to a minimum. The exposed metal parts of electrical apparatus are grounded to lead off any power line voltage that may reach them in event of a short circuit.

In review, there is a double safeguard on practically each item. To be effective, however, the safeguard chain must be complete. Its incompleteness may, in itself, produce a hazard.

Shock and Fire Protection

When protection against explosion of gases is not a prime consideration, as in other areas of the hospital, one finds a different electrical environment. The safeguards against electrostatic spark are not in use, flooring is essentially nonconductive, and the power system is grounded. Safeguards are directed primarily toward the prevention of electrical shock and fire caused by defective wiring.

To protect against electrical shock it is essential to eliminate the possibility of personnel becoming conductors of electricity. To this end the exposed metal parts of electrical equipment should be grounded. The electrical contact the person makes through his feet to ground should be reduced to a minimum. With the cabinet of an apparatus grounded, any power voltage that reaches it because of a failure of insulation or other causes, is short circuited to ground. Because this ground

conductor is of very low resistance as compared to the human body, it serves as a bypass to protect against shock. The high resistance of dry leather or rubber further serves to insulate the person from ground.

Much electrical equipment in use has no provision for grounding. Frequently the provision made for grounding, especially in portable equipment, is not connected. Usually this lack of connection is due to a mismatch of the power cord plug on the apparatus and the wall power outlet which makes proper connection difficult. The use of a two wire extension cord makes grounding impossible. This awareness of ungrounded electrical equipment serves to emphasize the danger of highly conductive footwear.

Well designed conductive operating room shoes actually have a very high electrical resistance. Though their maximum resistance is specific at 250,000 ohms, their actual resistance is fairly close to this value. This high electrical resistance is developed through a special composition rubber or leather sole. Shoes that are highly conductive are perfectly safe in the operating room with a well designed conductive floor and ungrounded electrical power. They are definitely a hazard elsewhere.

Summary

The blind acceptance that a situation is safe is a hazard in itself. A discussion of various safeguards as they relate to anesthetic gas explosion and electrical shock is presented. A knowledge of the various safeguards and the theory behind their operation makes one more conscious of them. Their absence becomes conspicuous.

No original material is presented in this paper. It is all spelled out by the National Board of Fire Underwriters.*

*Standard of the National Board of Fire Underwriters for the Use of Flammable Anesthetics, Bulletin No. 56, (July) 1962.

1828 South Florida Avenue.

Hyperthyroidism in Subacute Thyroiditis

Report of Two Cases

EUGENE T. DAVIDSON, M.D.
LAKELAND

Hyperthyroidism is usually due to the hyperfunction of either a solitary adenoma or a diffuse or nodular goiter. Less frequent causes include thyrotoxicosis secondary to the excessive ingestion of thyroid hormone or to subacute thyroiditis. Two cases of the latter are the subject of this report. The obvious importance of establishing the diagnosis of subacute thyroiditis lies in the fact that its management is entirely different from that of other more common causes of hyperthyroidism.

Report of Cases

Case 1. — A 47 year old diabetic housewife noted cardiac palpitation and an increase in her insulin requirement from 45 to 65 units over a period of two and one-half months. She also experienced tremulousness, easy fatigability, sweating, heat intolerance, and loss of 10 pounds in weight. She had had mild pain and swelling in the thyroid area for approximately three weeks, but no pain during the two weeks immediately preceding her visit to the clinic. There was no history of mumps or recent mumps contact.

Physical examination disclosed the body weight to be 118 pounds, height 66 inches, blood pressure 130/85 mm. Hg, and pulse rate 130 per minute. The temperature was normal. The skin was warm, moist and fine. There were no thyrotoxic eye signs. Exudates and capillary microaneurysms were present in both fundi. The thyroid was visible and diffusely enlarged with a slightly greater enlargement of the right lobe. Its estimated weight was 60 Gm. The gland was firm and nontender, and a bruit was audible over both lower poles. An active precordium was noted, and a grade II systolic murmur was audible along the upper left sternal border. The ankle jerks were absent. There was a large, myomatous uterus.

Laboratory data included protein bound iodine 9.2 mcg. per hundred cubic centimeters (normal 4 to 8 mcg.), red blood cell uptake of triiodothyronine (I_{131}) 30.5 per cent (normal 12 to 18 per cent), radioactive iodine (I_{131}) uptake by the thyroid in four hours 6 per cent, in six hours 5 per cent, and in 24 hours 3 per cent (normal 15 to 33 per cent in 24 hours). There was insignificant radioactivity over the pelvic mass in 24 hours. The routine blood and urine analyses gave normal results. A serum calcium determination was 10 mg. and a serum cholesterol determination 206 mg. per hundred cubic centimeters.

Treatment consisted of prednisolone, 30 mg. daily in divided doses, reduced to 10 mg. a day gradually over a one month period. The patient became clinically euthyroid one month after initiation of therapy, and was gaining weight. Seven weeks after therapy was begun, and while she was receiving 10 mg. of prednisolone daily, hypothyroid symptoms developed with a protein-bound iodine determination of 1.7 mcg. and a cholesterol determination of 508 mg per hundred cubic centimeters. Thyroid therapy was instituted; the dosage was increased to 3 grains daily as prednisolone was discontinued. On

her final visit, she was euthyroid on this regimen and the thyroid gland had returned to normal size. The insulin requirement and body weight were back to their previous values of 45 units and 128 pounds.

Comment.—This patient had subacute thyroiditis without thyroid tenderness, which simulated clinically the type of hyperthyroidism seen with diffuse toxic goiter. On careful questioning, a history of mild soreness in the anterior portion of the neck was elicited, and the diagnosis of thyroiditis was confirmed by radioactive iodine uptake and subsequent course.

Case 2.—A 42 year old white woman was seen for preoperative medical examination and evaluation of a thyroid nodule. There was a history of easy fatigability, weakness, loss of 11 pounds in weight, two to three watery stools per day, heat intolerance and palpitation over a three month period. Two weeks prior to her visit to the clinic she noted tenderness of the neck and enlargement of the left lobe of the thyroid. She had had mumps two years prior to this visit. A sister had had thyroid surgery five years earlier, the reason for which was not known to the patient.

Physical examination disclosed a blood pressure of 130/70 mm. Hg, pulse rate 120 per minute, weight 119 pounds, height 62¼ inches, and a normal body temperature. She was hyperkinetic, and the skin was smooth, fine and warm. There was subungual separation of the fingernails (onycholysis). No thyrotoxic eye signs were present. The thyroid gland was diffusely enlarged and tender. The left lobe contained an ill-defined 3 by 3 cm. nodule which was especially tender. There was no bruit over the thyroid area, but a grade II pulmonic systolic murmur was present. Deep tendon reflexes were hyperactive.

Laboratory studies showed protein-bound iodine 11.5 mcg. per hundred cubic centimeters, red blood cell uptake of triiodothyronine (I_{131}) 24.6 per cent, radioactive iodine (I_{131}) uptake by the thyroid 6 per cent in 24 hours, and routine blood and urine analyses normal.

The patient was treated with prednisolone, 60 mg. daily, gradually reduced over a 10 day period to 20 mg. a day. After two weeks of therapy tenderness in the neck was no longer present, and heat intolerance was almost gone. Prednisolone was gradually decreased, and after five weeks of therapy the thyroid was nontender and barely palpable, and the protein-bound iodine was 5.6 mcg. At this time, prednisolone was discontinued. One month later, the thyroid tenderness returned and the nodule again became palpable. Treatment with prednisolone was briefly resumed and thyroglobulin (Proloid) was added to the regimen. Subsequently, the pain in the neck disappeared, and the gland returned to normal size. She has continued to receive 2 grains of thyroglobulin per day and is now well after 12 months follow-up.

Comment.—This patient was seen for evaluation prior to proposed surgical removal of a thyroid nodule. Tenderness of the thyroid gland and a low radioactive iodine uptake established the diagnosis of subacute thyroiditis. A recurrence of the symptoms on discontinuation of the steroid therapy was readily controlled by the reinstitution of steroids and addition of thyroglobulin therapy.

Discussion

Subacute thyroiditis has been described in association with several viral diseases including mumps,[1] measles,[2] and cat scratch disease.[3] The associations have been infrequent although subacute thyroiditis is often accompanied by symptoms of infection of the upper part of the respiratory tract. The physical signs of pharyngitis may also be present. Pain coming directly from the thyroid gland may be confused, however, with symptoms referable to the upper segment of the respiratory tract, and the actual presence of subacute thyroiditis may be overlooked.[4]

If the infection is of viral etiology, a possible route of access to the thyroid gland is from the pharynx, possibly via the lymphatics. The virus probably disrupts the cells of thyroid follicles allowing their colloid contents to spill into the parenchyma of the gland. The colloid is believed to initiate the inflammatory reaction of the granulomatous giant cells observed on histologic section of the gland. This reaction is described as histologically similar to that present in experimental animals after the injection of colloid or the implantation of thyroid tissue subcutaneously.[5] The pathology of subacute thyroiditis has recently been reviewed,[6,7] as have its clinical aspects.[8,9]

From the colloid released from the follicle into the parenchyma of the gland, thyroid hormones and their precursors escape into the blood stream.[10] If sufficient quantities of hormone escape, thyrotoxic symptoms occur. The large store of hormone within the gland makes this result possible.

Clinically, the inflammatory reaction within the gland is manifested by cervical pain in the thyroid area with frequent radiation into the ears, dysphagia, thyroid enlargement and tenderness, fever, and elevation of the sedimentation rate. Fever is occasionally present with the other types of hyperthyroidism, and may not be secondary to the inflammatory process alone.

The release of thyroid hormones from the gland in sufficient quantities results in an alteration in thyroid function studies. The protein-bound iodine, basal metabolic rate and red cell or resin T-3 uptake may all increase. The characteristically low radioactive iodine uptake, almost invariably below 10 per cent in 24 hours and usually much lower, may be due either to the inflammatory reaction in the gland or to the suppression of secretion of thyroid-stimulating hormone from the pituitary. In the latter case, this is due to an increase in the circulating thyroid hormone released from the thyroid gland. The glands of patients whose protein-bound iodine and basal meta-

bolic rate values are not elevated show low radioactive iodine uptakes, favoring the inflammatory concept. Even in these patients there may be associated escape of thyroid hormone into the blood in amounts sufficient to suppress endogenous thyroid-stimulating hormone but insufficient to elevate the basal metabolic rate and protein-bound iodine determination.[11] Administration of thyroid-stimulating hormone has been reported to increase the radioiodine uptake by the thyroid gland in the acute stage of subacute thyroiditis,[12] indicating that the gland is sensitive to its presence. The thyroid-stimulating hormone uptake response in some cases is subnormal, however, probably indicating some direct effect by the inflammatory process upon the radioactive iodine uptake. Further data are necessary to clarify this concept.

The diagnosis of subacute thyroiditis is not difficult when there is pain in the thyroid area radiating into the ears and associated with a tender, firm thyroid enlargement. This is true despite the resemblance of the thyroid gland to the diffuse goiter, the multinodular goiter or the thyroid adenoma. The clinical impression of subacute thyroiditis is confirmed by an elevated sedimentation rate and low radioiodine uptake. As in the first case presented, however, thyrotoxic symptoms may overshadow signs of inflammation and thyroid tenderness may be absent. In such an instance confirmation of the diagnosis by demonstrating a low radioiodine uptake is most important. Lid retraction has been reported in subacute thyroiditis.[1] It is noteworthy that thyrotoxic eye signs were absent in both cases reported. Hyperthyroidism from subacute thyroiditis should be considered more strongly in cases in which classic thyrotoxic eye signs are absent.

Subacute thyroiditis is a self-limited illness subject to frequent spontaneous relapses, making therapeutic evaluation difficult. Adrenal corticosteroid, corticotrophin and x-ray therapy all appear to hasten symptomatic recovery. X-ray therapy and surgery are still being used in some institutions in rare cases reportedly resistant to corticosteroids or corticotrophin. Since this is a disease of limited duration, surgery should not be considered a part of its therapy. Salicylates will ameliorate or relieve the symptoms in the milder cases, serving as an effective substitute for adrenal corticosteroids. Hypothyroidism may develop in the natural course of the disease whether treated or untreated. Administration of thyroid hormone in full replacement dosage will prevent or correct hypothyroidism and its long term use may assist in the elimination of recurrent thyroiditis. It is usually administered conjointly with either salicylates or adrenal steroids. Hypothyroidism is usually only transient when associated with this disease; however, its persistence is occasionally noted even without associated x-ray therapy.[9,13] Thyroid administration can therefore be discontinued on a trial basis months after the disease clears. By depleting the gland of its stored thyroid hormone, thyroid administration could be expected to prevent thyrotoxic symptoms from occurring with recurrence of the thyroiditis.

Summary

Two cases of subacute thyroiditis with associated hyperthyroidism are reported. The importance of a careful inquiry into the presence of pain or tenderness in the anterior portion of the neck in all patients with thyrotoxicosis is stressed as is the use of radioiodine uptake in the routine diagnostic evaluation of thyrotoxicosis. The necessity for an accurate diagnosis of subacute thyroiditis because of its benign self-limiting course is pointed out. Only thus can unnecessary surgery and radioiodine therapy be eliminated. The clinical pathophysiology of subacute thyroiditis is briefly discussed.

Appreciation is expressed to Dr. John P. Gifford of Vero Beach for referring the patient in case 1 and allowing her case to be reported.

A critical review of this paper by Drs. Jere W. Annis and John V. Verner Jr. is also appreciated.

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Watson Clinic.

Primary Sarcoid Heart Disease

Report of a Case

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CORAL GABLES

The purpose of this paper is to present a fatal case of myocardial sarcoidosis and review the clinical features and postmortem findings in 29 proved cases reported in the literature. The incidence and etiology of sarcoidosis will be discussed and the historical background of primary sarcoid heart disease will be presented.

Primary sarcoid heart disease is to be distinguished from cor pulmonale due to long-standing sarcoidosis of the lung. The primary form is now recognized as a dangerous and often fatal complication of sarcoidosis. It was approximately 26 years ago when the first fatality due to myocardial sarcoidosis was presented by Gentzen.[1] Upto the present time, almost 40 cases have been reported which are unrelated to cor pulmonale.

Historical

Recognition of the possibility of myocardial involvement with sarcoid did not occur until 1929 when Bernstein and his associates[2] published the first report in the English literature of an autopsy case with cardiac lesions consisting of nodules of the epicardium as well as invasion of the superficial myocardial fibers. No clinical evidence of cardiac abnormality was reported. It must also be mentioned that although sarcoidosis was the diagnosis, a serological test for syphilis gave positive results on both blood and pleural fluid of the patient. In 1935, Salvensen[3] was the first to emphasize the importance of electrocardiographic changes in the disease when he recorded the history of a patient with Boeck's sarcoid whose electrocardiograms showed right bundle-branch block, alternating with a regular rhythm. No autopsy substantiation of cardiac involvement was available as the patient was still living at the time of the report. Just prior to this report, Garland and Thompson in 1933 reported a case of uveoparotid tuberculosis with massive involvement of visceral pericardium and myocardium that met all criteria for sarcoidosis (no evidence of caseation in any lesions and negative results from studies of acid-fast bacilli).

In 1936, Schaumann[4] described four autopsied cases of sarcoidosis, the second of which demonstrated many lesions of the heart, but apparently limited to the epicardium. The patient died in congestive heart failure and the author expressed the opinion that this was due to increased pulmonary resistance caused by extensive sarcoidosis also present in the lungs. Nickerson[5] in 1937 demonstrated in one of six autopsied cases sarcoid lesions of the parietal pericardium. Gentzen[1] reported the first death due to myocardial sarcoidosis in 1937. Spencer and Warren[6] in 1938 presented a case of generalized sarcoidosis with lesions of the myocardium. In 1939, Cotter[7] reported a case with rapid progression and death in congestive heart failure attributed to extensive sarcoidosis of the heart and proved at autopsy. Jonas[8] in 1939 also described five cases of granulomatous myocarditis, the third case of which could not be distinguished from some of the typical cases of sarcoidosis with cardiac involvement. Again in 1939, Hirayama and Brosig separately described cases of sarcoidosis with myocardial lesions.[9] In the last 20 years it has become increasingly apparent that sarcoidosis can be a cause of heart disease unrelated to cor pulmonale.

Etiology

The etiology of sarcoidosis is still uncertain. A variety of organisms has been implicated, but as yet no substantiating proof is evident. Among these are bacteria, viruses, fungi and animal parasites as well as certain compounds. A similarity to other diseases has also been emphasized.

A current theory of etiology centers around a type of hypersensitivity reaction due to exposure to pine pollen.[15] The pollen has been shown to contain waxes similar to those of tubercle bacilli and to produce similar epithelial lesions on injection. The presence of certain pathologic changes along with oft-noted aberrations in serum proteins lends support to a role of hypersensitivity.

Mankiewicz[10] contended that certain cases of sarcoidosis are due to "modified" tubercle bacilli. Six lymph node specimens for biopsy collected from patients with sarcoidosis were cultured on a variety of mediums from which five variant strains of tubercle bacilli were isolated.

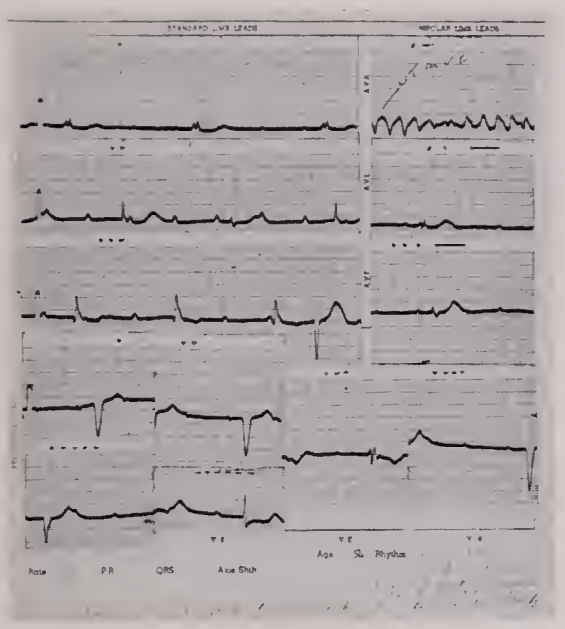


Fig. 1.—Electrocardiographic evidence of complete atrioventricular block and left bundle-branch block. Premature ventricular beats and arrhythmia in AVR compatible with ventricular tachycardia or possibly ventricular fibrillation.

When heart disease presents itself suddenly and without recognized etiology, it behooves the attending physician to include myocardial sarcoidosis in the differential chain of possibilities. The following case is illustrative and is especially noteworthy in that it involves a death from primary sarcoid heart disease in a white woman who had no past history or clinical manifestations of the disease other than those relative to the heart.

Report of Case

A 54 year old, white, female meat-packer was seen in the hospital on the early morning of Jan. 21, 1961, for tightness and pain in the chest, shortness of breath and nausea. A sore throat with some fever 10 days previously was followed by dyspnea and cough for the last four days. On the night before admission and prior to coming to this hospital, she had gone elsewhere and was seen by a resident physician who gave her 1 mg. of reserpine (Serpasil) intravenously. He noted that her blood pressure at that time was 200/70 mm. Hg and the pulse rate 36. The family history was unrevealing except for the fact that one brother had tuberculosis and a twin brother had diabetes. The past history included some eye difficulty in 1949. She stated she was told at that time that she had glaucoma of the right eye. It is to be noted, however, that a cataract was removed from the left eye in 1949.

On physical examination, moist rales were present throughout the chest, both posteriorly and anteriorly. Breath sounds were difficult to hear. The liver was not tender or enlarged and no hepatojugular reflux was noted.

Laboratory studies revealed that the hemoglobin level was 13 Gm., hematocrit level 39 per cent and white blood cell count 7,100 with 76 per cent segmented forms; lactodehydrogenase 350 units; antistreptolysin 0 titer 50 Todd units; C-reactive protein 3 plus in two hours and 4 plus in four hours. Transaminase on January 22 was 62 units and on the following day 26 units. Urinalysis disclosed a trace of albumin, specific gravity 1.016 and microscopically seven to 10 white blood cells per high power field.

An electrocardiogram at this time showed complete AV and bundle-branch block (fig. 1). One run of ectopic ventricular beats resembled ventricular fibrillation in AVR. Also, premature ventricular contractions were noted elsewhere.

A roentgenogram of the chest (fig. 2) showed heavy markings bilaterally consistent with the picture of pulmonary congestion and possibly pulmonary edema. The heart showed generalized enlargement with a cardiac-thoracic ratio of 15 to 26. The aorta was slightly tortuous and no mediastinal or other lymph nodes were noted.

The patient was placed on bed rest and given a congestive failure regimen. She became symptomatically better on this routine and lost weight. Subsequent electrocardiograms showed varying degrees of AV block; however, at one time the pulse at the radius was 62. It was intermittent and occasionally the pulse would drop as low as 26. The blood pressure remained fairly stable, between 130 and 140 mm. Hg, with the diastolic pressure around 70 mm. Hg. She was given prednisone and isoproterenol (Isuprel) without any untoward effects, but they did not seem to accelerate the rate or benefit in any way. She experienced an episode of syncope on February 5, but did not lose consciousness. The pulse rate at that time was 30 and the blood pressure was 140/70 mm. Hg. On February 17, four weeks after admission to the hospital, she was found dead in bed. Five minutes prior to this time, she had been seen by a nurse and there had been no complaint of feeling ill.

Autopsy.— The heart weighed approximately 350 Gm. The coronary ostia were widely patent. The medial surface of the left atrium presented a small, whitish, tumor-like mass infiltrating the entire thickness of the wall. The left ventricle averaged 15 mm. in thickness. On section, most of the interventricular septum, including the region of the AV node, was replaced by firm, whitish, tumor-like tissue (figs. 3 and 4). The muscle had been entirely replaced. This area extended from the base of the heart to the apex and measured approximately 4 cm. in diameter. The remainder of the heart, the aorta and the main branches were free of this involvement. Some involvement of the peritracheal, peribronchial and periesophageal lymph nodes was present. These measured up to 3 cm. in greatest diameter. The left lung had pleural involvement in the form of small, white plaques, which were also scattered over the subcapsular portion of the liver.

In summary, the pathological diagnosis was generalized sarcoidosis involving the peripheral portions of the lungs bilaterally, the interventricular septum and the left atrium of the heart, the subcapsular portion of the liver, and the mediastinal and peripancreatic lymph nodes.

This case of primary cardiac sarcoidosis presented no clinical evidence of sarcoid disease other than cardiac manifestations. There was no past history of illness due to this disease, except for the speculation that the eye difficulty could conceivably have been due to sarcoid disease. It is to be noted that the routine treatment for heart block was not encouraging, except for one occasion when the pulse was accelerated somewhat. No pacemaker was used on this patient.

Incidence of Sarcoidosis

Various estimates have been made, but as yet no precise knowledge of the incidence of sarcoidosis in the general population is available.[26] The



Fig. 2.—Gross cardiac enlargement. No evidence of sarcoidosis in the mediastinum, lungs or pleura.

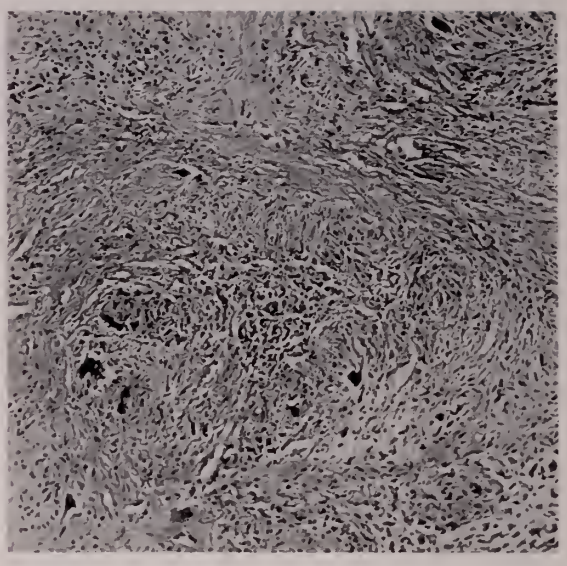


Fig. 3. — Section from interventricular septum. Microscopically, tubercles are formed by concentric epithelial cells. Multinucleated giant cells and the absence of necrosis and acid-fast bacilli are characteristic.



Fig. 4.—The arrows show a 2.5 by 1.3 cm., tan and white, granulomatous area high in the interventricular septum.

latest evaluation places it at about one to four per 10,000 young adults. Routine fluoroscopy of greater than 500,000 recruits of the Swiss army revealed an incidence of 0.13 per 1,000.[15] In the span of years of 1928-1948, a diagnosis of sarcoidosis had been made approximately 80 times by biopsy at the Massachusetts General Hospital. The occurrence of myocardial involvement with generalized sarcoidosis has been estimated from autopsy material at about 20 per cent. The presence of sarcoids in the myocardium or pericardium was demonstrated in four of the 21 recorded autopsies of Bernstein, Konzelmanl and Sidlick, Schaumann, Nickerson and Cotter. A survey of 31 cases of sarcoid was made at the Johns Hopkins Hospital during 1925-1940. Six of the patients presented evidence during life of some derangement of the heart action or showed at autopsy sarcoids in the myocardium or pericardium or in both locations.

Thirty cases of myocardial sarcoidosis are recorded in table 1. They represent 75 per cent of the total number reported to date. Seventeen patients were of the white race; this figure is a marked reversal of the expected number since the incidence of sarcoidosis is many times higher in the Negro. This finding would lead to the belief that the heart is more vulnerable in the white race. Sudden death occurred in 18 patients or 60 per cent of the total number of cases. Congestive failure ensued in 11 patients or 36 per cent. Conduction defects in the form of heart block were present in 16 cases. Various arrhythmias, including sinus tachycardia, premature ventricular beats and ventricular tachycardia, made up the bulk of this complication. Clinically and pathologically, the white women seemed to follow a similar pattern. Almost without exception, they gave no past history of sarcoidosis. Their deaths were sudden

Table 1. — Clinical and Postmortem Correlation of 30 Cases of Primary Sarcoid Heart Disease

Case	Age	Race	Sex	Clinical Course	EKG Findings	Heart Lesion	Cause of Death
1 1	38	W	M	Congestive heart failure, recurrent arrhythmias	Recurrent arrhythmias	Myocardium	Congestive heart failure
2 36	47	W	M	Chest pain Sudden death	Ventricular premature contractions	Myocardium, endocardium, papillary muscles	Sudden cardiac death
3 48	40	W	M	Progressive myocardial failure	Sinus tachycardia	Myocardium, pericardium, endocardium	Congestive heart failure
4 49	48	W	M	Rheumatic heart disease, with failure Sudden death after mitral valvulotomy	First degree atrioventricular block	Epicardium, myocardium, interventricular septum	Sudden cardiac death
5 39	33	W	M	Sudden death Multifocal premature ventricular contractions, otherwise apparently well	Multifocal ventricular premature contractions	Myocardium, endocardium, papillary muscles, interventricular septum	Sudden cardiac death
6 50	24	W	M	Minimal dyspnea Sudden death	Complete atrioventricular block	Myocardium	Sudden cardiac death
7 11	19	W	M	Adams-Stokes syndrome Sudden death	Complete atrioventricular block	Myocardium, atrioventricular bundle	Sudden cardiac death
8 51	51	W	M	Cardiac enlargement presystolic gallop rhythm, palpable liver, other signs of congestive failure	Atrial flutter first degree AV block	Myocardium, pericardium	Cardiac failure
9 55	44	W	M	Dyspnea, pain in back; precordium	Premature ventricular contractions AV block	Myocardium	Sudden death Cardiac arrest
10 34	42	W	F	Adams-Stokes syndrome for 15 years Sudden death	Complete atrioventricular block	Myocardium interventricular septum	Sudden cardiac death
11 53	54	W	F	Adams-Stokes syndrome Sudden death	Complete atrioventricular block	Myocardium, interventricular septum	Sudden cardiac death
12 46	27	W	F	Adams-Stokes syndrome Sudden death	Complete atrioventricular block	Myocardium, atrioventricular bundle	Sudden cardiac death
13 40	32	W	F	Adams-Stokes syndrome Sudden death	Complete atrioventricular block	Myocardium, atrioventricular node, interventricular septum	Sudden cardiac death
14 50	40	W	F	Past history of tuberculosis Sudden death while working in field	Complete atrioventricular block	Myocardium, interventricular septum	Sudden cardiac death
15 16	51	W	F	Ankle edema, syncope, congestive failure	Heart block with idioventricular rhythm Left bundle branch block	Septal invasion, almost complete	Congestive heart failure
16 16	76	W	F	Syncopal attacks, ventricular standstill, intermittent	Third degree heart block. Premature ventricular contractions, bigeminal rhythm	Septum, almost completely replaced by sarcoidosis	Ventricular standstill Sudden death
17 8	24	N	F	Palpitation, syncope Sudden death	Paroxysmal ventricular tachycardia	Myocardium, papillary muscles, interventricular septum	Sudden cardiac death

18 25	45	N	F	Progressive myocardial failure	Paroxysmal atrial tachycardia	Myocardium	Congestive heart failure
19 25	27	N	F	Sudden death	Paroxysmal ventricular tachycardia	Myocardium	Sudden cardiac death
20 35	55	N	F	Granulomatous uveitis Sudden death	Sinus arrhythmia, sinus brachycardia	Myocardium	Sudden cardiac death
21 34	28	N	M	Congestive heart failure	Paroxysmal ventricular tachycardia	Myocardium	Congestive heart failure, ventricular tachycardia
22 25	46	N	M	Progressive myocardial failure	Complete atrioventricular block	Myocardium, pericardium	Congestive heart failure
23 19	24	N	M	Progressive myocardial failure	Multifocal ventricular premature contractions, paroxysmal ventricular tachycardia	Myocardium	Congestive heart failure
24 31	31	N	M	Persistent sinus tachycardia	Sinus tachycardia, ST segment and T wave changes	Myocardium, papillary muscles, interventricular septum	Sudden cardiac death
25 32	25	N	M	Failing vision Sudden death No suspicion that patient was seriously ill	Paroxysmal ventricular tachycardia	Myocardium	Sudden cardiac death
26 33	42	N	M	Adams-Stokes syndrome, auriculoventricular disassociation	AV dissociation	Pericardium, myocardium	Suicide
27 24	20	N	M	Progressive myocardial failure	Sinus tachycardia	Pericardium, myocardium	Medical shock, vascular collapse
28 7	18	N	M	Congestive failure cyanosis, edema	Sinus tachycardia bundle branch block atrioventricular block	Myocardium	Progressive myocardial failure
29 1	41	?	M	Adams-Stokes syndrome Sudden death	Complete atrioventricular block	Myocardium	Sudden cardiac death
30 *	54	W	F	Congestive failure, Stokes-Adams syndrome Sudden death	Complete atrioventricular block, bundle-branch block, premature ventricular beats	Interventricular septum, myocardium	Probable asystole Sudden death

*Author's case.

and at autopsy the site of involvement was the interventricular septum.

Sarcoidosis can occur at any age, but is most common from 15 to 50 years with a broad incidence in the third to fourth decade. There appears to be no sex preferential as the disease has about the same incidence in both men and women. Its occurrence is worldwide, but it is prevalent in the United States, Scandinavia, England, Switzerland and Germany. The much higher incidence in Negroes as compared to whites is of note with most studies showing at least a 17 to one ratio. Multiple cases within families are not uncommon and affliction of identical twins has been noted. Berger described a family of seven siblings, five of whom had sarcoidosis proved by biopsy. Robinson and Haln noted its occurrence in two unrelated Negro families. In one family, at least two of the three siblings were affected, whereas in the other, which included 10 siblings, a positive diagnosis was established in three and a probable or possible diagnosis in three others.

Pathology

The classic picture of sarcoidosis consists of tubercle-like nodules of granulomatous tissue formed by epithelioid and reticuloendothelial cells enclosing the typical multinucleated giant cells of the foreign body type; the absence of eosinophils, polymorphonuclear leukocytes and caseating necrosis is noted. The histological appearance of the lesion is subject to variations, some lesions having small central necrotic foci. Late, when involution is complete, the entire nodule is replaced with fibrous tissue. Star-shaped acidophilic bodies, referred to as asteroids, and spherical or ovoid basophilic bodies are found infrequently within giant cells.

Lesions in the heart do not differ much from those found elsewhere, except that they tend to show a linear type of nodular growth as opposed to the rounded, well circumscribed granulomas usually seen in the reticuloendothelial system. This tendency may be explained partially by the syncytial nature of the myocardium. No area of the heart is immune to involvement with sarcoidosis and the extent of damage varies from case to case. Small foci may appear in the ventricular wall as well as combined lesions in both ventricles, papillary muscles, interventricular septum and endocardium. Lesions of the conduction system occur in as high as 40 per cent of cases.

Discussion

Since 1952, when Longscope and Freiman[12] showed that sarcoid of the heart occurs in approximately 20 per cent of the cases of generalized sarcoidosis autopsied, the available data on myocardial sarcoid as a cause of death have increased in the literature. Resnier[13] stated that the heart may become involved in two ways, either through direct invasion by sarcoid tissue, particularly of the myocardium, or indirectly as a result of extensive pulmonary changes of long standing which may eventually cause failure of the right side of the heart.

Scotti and McKeown,[14] in a summary of 13 cases confirmed by autopsy, dissected the coronary arteries and found no obstructive lesions, either at the orifices or along the course of the vessels, to account for fibrosis as well as no gross histological evidence to indicate rheumatic fever or syphilis. They attributed death in their cases to the active lesions extensively involving the myocardium along with the prominent fibrosis. It was the consensus of authors who have investigated the subject that death, when it occurs, is usually due to extensive myocardial infiltration with resultant fibrosis and most frequently myocardial failure.[11] Most of the cases of sudden death due to myocardial sarcoid have been attributed to ventricular fibrillation or to Stokes-Adams syndrome.[15]

Involvement of the heart with sarcoidosis has been manifested by various clinically demonstrable irregularities, such as rhythm disturbances, transient or permanent heart block, cardiac enlargement, congestive heart failure and other electrocardiographic abnormalities.[11] Conduction disturbances are the most common clinical manifestations and in about 50 per cent of fatal cases of sarcoid heart disease some portion of the conduction system is involved. The electrocardiographic patterns, as stated by Porter, are frequently unstable and varying degrees of atrioventricular and intraventricular block are present in the same patient at the same time during his illness. The most frequent conduction disturbance has been complete atrioventricular heart block. First degree and second degree heart block and simple intraventricular conduction delay occur in about equal frequency and are second in the rate of occurrence. The three together account for over 50 per cent of the electrocardiographic findings. The second most common clinical manifestation is arrhythmias which are frequently paroxysmal. They consist primarily of paroxysmal ventricular tachycardia, paroxysmal atrial tachycardia, sinoatrial node aberrations and frequent ventricular premature contractions.

In patients in whom death has been directly attributable to myocardial sarcoid lesions, many have died unexpectedly. Porter[11] reported two thirds of his patients so affected. In a significant number of cases, no previous cardiac symptoms were noted. Congestive heart failure accounts for the remaining deaths that do not occur suddenly.

Although the prognosis in a patient with manifestations of sarcoidosis of the myocardium is usually grave, cases have been reported in which the effects were only transient in nature. Thus, it would appear that the lesions may heal and, if important pathways or structures in the heart muscle are not permanently injured, improvement may occur. Once the critical pathways are damaged, only limited regenerative potential remains and a downhill course with development of further conduction abnormalities is the rule.

Treatment

Treatment of sarcoidosis through the years has been identified with various remedies which now are rejected. Some of those previously employed have been gold salts, arsenic, chaulmoogra oil, x-ray, calciferol, dihydrotachysterol, ultraviolet light and antituberculous drugs.[15] At the present time, adrenal steroids, together with symptomatic treatment, bed rest and a diet regimen in indicated cases, are being employed. The steroids appear to exert a suppressive effect and a return to previous status is usually noted upon their cessation. Cardiac complications, such as congestive failure and arrhythmias, are treated in the conventional manner. Heart block is a frequent and a troublesome complication and at the present time no cases with favorable modification secondary to cardiac sarcoidosis have been reported.[11] It is believed by some that the institution of steroid therapy early in the course of the disease, or as soon as abnormalities appear in electrocardiograms, may lead to clinical improvement. Isoproterenol and other cardiac drugs have been used with some degree of success in Stokes-Adams attacks. The pacemaker was instituted by Finney,[45] but was relatively ineffective after initial success in two cases.

Summary

The developmental history, incidence, etiology, clinical aspects and pathological description of sarcoidosis are discussed.

A case of myocardial sarcoidosis is presented in which sudden death ensued. The patient had exhibited no clinical history of the disease and was the eighth white woman reported to be so affected. It is to be noted that in women with cardiac sarcoidosis the disease followed an almost identical clinical and pathological pattern (table 1).

Sudden death occurs in approximately three fourths of the patients with myocardial sarcoidosis and the physician should be ever alert to its possibility. Patients with generalized sarcoidosis in whom persistent tachycardia, Stokes-Adams attacks, arrhythmias and congestive failure develop should be considered to have myocardial involvement with sarcoidosis. Those patients without systemic involvement may be suspected of having cardiac sarcoidosis if the findings described are present and the etiology is not apparent. Serious cardiac complications have been noted with about equal frequency in the white and Negro races.

Twenty-nine additional cases are reviewed with antemortem and postmortem cardiac findings. Treatment consisted of pressor agents, steroids, congestive failure regimen and a pacemaker. In spite of these methods of treatment, the patients derived little benefit and subsequently died.

I am indebted to Maxwell M. Sayet, M.D., and W. T. Winter, M.D. for their assistance.

References are available from the author upon request.

401 Coral Way.

Infections Due to Unclassified Mycobacteria in Florida

S. Howard Ferguson, M.D., Robert F. Gorske, E. Charlton Prather, M.D., and Albert V. Hardy, M.D.
JACKSONVILLE

Since the initiation of cultural procedures for the bacteriological diagnosis of tuberculosis, it has become increasingly evident that forms of acid-fast bacilli which differ from Mycobacterium tuberculosis are often found in the examination of sputums. As far back as 1935 Pinner[1] emphasized the need for a critical evaluation of the significance of such organisms commonly referred to as the "atypicals." The report by Crow and his associates[2] in May 1956 of a series of cases observed in the Battey State Tuberculosis Hospital, Georgia, was the first indication that these atypi-

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cal organisms apparently had substantial clinical and public health importance.

In Florida there was an early concern with these infections. In 1955 the Florida State Board of Health and the Florida Tuberculosis Hospitals began a cooperative investigation of cases yielding these organisms. Since that time "unclassified Mycobacteria" have been isolated from more than 2,500 persons. The differentiation of the unclassified Mycobacteria from M. tuberculosis is readily effected by a number of laboratory tests. Mycobacterium tuberculosis is pathogenic for the guinea pig; unclassified Mycobacteria are not. This organism produces niacin, indicated by a positive yellow coloration in the niacin test, and is, therefore, niacin-positive. The unclassified Mycobacteria on the contrary are niacin-negative. The identification of an acid-fast organism on a smear no longer justifies a diagnosis of pulmonary tuberculosis. The major concern of the continuing studies has been to establish the relative significance of these organisms and to determine their sources and modes of dissemination. A summary of observations, conclusions and current uncertainties follows.

Classification

Based upon the work of Runyon[3] the unclassified Mycobacteria fall into four major groups, indicated for reporting purposes by Roman numerals I, II, III and IV.

It is generally accepted that the organisms of Group I (now being named Mycobacterium kansasii) are the most highly pathogenic, followed by those of Group III. Groups II and IV have been considered nonpathogens, but recent reports and our experience indicate that these may be involved in local infections, as of lymph glands, or pleural or joint effusions and probably also of pulmonary infections under conditions as yet undefined. Epidemiologically, all of the unclassified Mycobacteria differ from M. tuberculosis in that they may be found in man in the absence of any demonstrable disease. The discovery of M. tuberculosis indicates with virtually no exceptions the presence of a pathological process. In contrast, the unclassified Mycobacteria or organisms with very similar characteristics can be found in nature in a variety of sites. Thus, the epidemiology of these infections has complexities, interests and variety which make M. tuberculosis infections, epidemiologically, seem very simple indeed.

The relative frequency with which these infections have been found is shown in table 1. Throughout our studies the more pathogenic Group I has accounted for 4 per cent of our cases. In contrast, in 60 per cent of the cases the cultures yielded Group III organisms, as is shown. In 22 per cent of the cases with positive results the cultures yielded Group II and 14 per cent yielded Group IV.

The picture is modified if one considers only the cases in which it may be presumed or suspected that the infection has clinical significance. These would include the cases that have multiple positive cultures with multiple colonies on the positive specimens. Also, it would exclude those in which there is a proved or presumed M. tuberculosis infection, either preceding or concurrent. To guide in our studies, we have identified these presumably more significant infections. The cases are distributed as shown in the second column of table 1.

Distribution

Group I infections still account for only 7 per cent of the total, but it is worthy of note that in most instances in which this infection is present, the evidence indicates that it is usually the responsible pathogen. Again, a high proportion (85 per cent) of all cases considered more significant was due to Group III. Of all positive isolations of this organism, however, less than one half were considered of possible clinical significance. A relatively small percentage of Group II and Group IV infections appeared to be pathogenic. It is recognized that organisms producing a pathological process may be discharged in small numbers, if at all. Hence, one cannot lightly dismiss a positive bacteriological finding with a few colonies only. Nevertheless, more weight, and we believe major weight, should be given to those cases in which these organisms are being discharged in substantial numbers, particularly when they are found repeatedly. These presumably more significant infections are the ones on which we are attempting to obtain full laboratory, epidemiological and clinical information.

For purposes of comparison, the distribution of clinical cases in Georgia believed due to these organisms is shown in column 3 of table 1. As noted, they attribute a very high proportion to Group III, commonly designated as the Battey strain, a small percentage to Group I, an occasional case to Group IV and none to Group II.

The distribution by race and sex is given in table 2. For both races, the infections predomi-

Table 1.—Relative Frequency of Occurrence of Identified Infections With Unclassified Mycobacteria

Atypical Type (Group)	Total Florida Cases*		Total Clinically Significant Cases		Identified in Georgia	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
I	87	4	62	7	12	4
II	478	22	44	5	0	0
III	1,304	60	747	85	285	94
IV	304	14	26	3	6	2
	2,173	100	879	100	303	100

* Number of cases reported through Dec. 31, 1962.

nate in the male. There is no marked variation by race with the exception that virtually all of the Group I infections in Florida have been in the whites. In the whites the incidence is roughly three males to one female, whereas, in M. tuberculosis infections the ratio is approximately two males to one female. The attack rate in males per 100,000 is 13.4 for whites, but 20.0 for nonwhites.

By age, these unclassified mycobacterial infections have the same general distribution as tuberculosis. Infections are relatively rare in the young and have increasingly higher attack rates with increasing age.

No area in Florida is free of these infections. There is, however, variation in frequency of occurrence. In general, they are present less frequently in South Florida and in the urban population. They occur more frequently in Central and North Florida and particularly in the crest area of the Florida peninsula.

There are, at most, minor differences in the seasonal distribution of these infections.

From the beginning of these studies there has been particular interest in the possible occurrence of clusters of cases such as would be expected in infections spread from man to man. The striking feature has been the absence of these. No secondary clinical case has occurred in the immediate family. The nearest was a nephew and uncle living in separate households, the former with a primary Group III infection, the latter with concurrent lung cancer and a positive Group III culture on lung tissue removed surgically. The occasional isolations of unclassified Mycobacteria from family contacts have included organisms in groups differing from, as well as the same as, those in the clinical case. Typically, the unclassified mycobacterial infections have occurred sporadically, widely scattered in space and time, and without case to case contact. All observations suggest a source other than the human case and one which must be widely and generally distributed.

Tuberculin Sensitivity

The natural history of these infections in Florida has been studied further through tuberculin surveys. Two antigens were used, standard tuberculin and a preparation prepared from a Battey strain by the Public Health Service. These are designated respectively: PPD-S (Standard) and PPD-B (Battey). Selected findings in these tuberculin surveys are shown in table 3. The striking feature in the findings shown is the wide variation from a low of less than 1 per cent to a high of 36 per cent (PPD-B) in one survey. The findings raise questions rather than answer them.

It appears probable that the occurrence of infection with the Battey strain may modify the skin sensitivity to PPD-S. Otherwise, it would be difficult to explain the high reaction rate for PPD-S where there is an even higher rate for PPD-B. The cross reactions of these related infections have not been clarified. Also from data as shown in table 3, it seems probable that reaction to the PPD-B antigen is much less stable than that to the standard tuberculin. In groups with multiple testing, utilizing in so far as can be determined identical techniques, the proportion of positives has changed from low to high, later reverting to a relatively low rate. Further exacting studies in this area are clearly indicated.

Florida 1962
Table 2.—Race and Sex Incidence of Persons Having First Isolations of Unclassified Mycobacteria

	Whites		Nonwhites		Unknown	Total
	Male	Female	Male	Female		
Number U.M.	290 (52.5%)	104 (18.9%)	94 (17.0%)	51 (9.3%)	13 (2.3%)	552 (100.0%)
Race and Sex Incidence of Persons Having First Diagnosis of Active Tuberculosis*						
Number T.B.	567 (39.4%)	264 (18.4%)	405 (28.1%)	202 (14.0%)	1 (0.1%)	1,439 (100.0%)

*Diagnosis may be established radiologically.

Table 3.—Dual Antigen Surveys — Florida 1959-1962

	Whites			Nonwhites		
	PPD–S	PPD–B	Total	PPD–S	PPD–B	Total
Sumter County—1959	1 (0.5%)	3 (1.5%)	199	8 (5.5%)	14 (9.7%)	145
Sumter County—1962	1 (0.4%)	13 (5.1%)	256	11 (6.4%)	61 (35.5%)	172
Brighton Seminole Indian Reservation				18 (10.1%)	12 (6.7%)	178

Clinical Data

Our files at the State Board of Health contain records on over 2,500 cases in which unclassified Mycobacteria have been isolated. Currently some 500 new cases are being added yearly.

Clinical notes vary from brief responses to mail inquiries, to detailed summaries of voluminous hospital records. Time permits only references to illustrate the marked variability in observations.

First, in the substantial number of cases in which Groups II, III and IV organisms were recovered, neither symptoms nor clinical findings suggest a new or aggravated infectious process. Likewise, there are substantial numbers of positive observations on sputum specimens collected, in the follow-up of known tuberculosis cases. Often neither clinical nor radiological observations detect any related change in the course of these cases. Most of the patients are those from whom unclassified Mycobacteria were isolated once only, and often with a finding of one, two or three colonies only. Are these acid-fast organisms nonpathogens, or are they findings of potential pathogens which are not invading, or may they indicate a subclinical invasion which may evolve into serious pathological change at some uncertain future time? The answers to these and other questions can be obtained only by long term follow-up; working together in the interest of the patient and of science, we in Florida can obtain the answers to these important questions.

Turning to severe cases, we have many, many records of grave illnesses with extensive destructive pathological conditions which progress, uninfluenced by the antituberculosis drugs currently available; these are cases with cultures repeatedly positive for unclassified Mycobacteria and negative for M. tuberculosis. There are those also in which the affected lobe or lobes have been removed and the bacteriological examination of the excised tissue yielded only unclassified Mycobacteria. In a scattering of cases extrapulmonary infection involved lymph glands, joints, kidneys and other sites. In a few cases of acute pulmonary disease the unclassified Mycobacteria were isolated, thus raising the question as to the role of these organisms as primary or associated pathogens in other than chronic disease. Here are samples from our records:

1.—A waitress, age 23, with previous normal films and without complaints, had a routine health card examination. A 1.5 cm. cavity was identified radiologically. Sputum specimens were repeatedly positive for Group I (M. kansasii). This patient had a lobectomy five months later and the surgical specimen yielded the same organism. There was no history of tuberculosis in the patient or her family and all cultures were negative for M. tuberculosis.

2.—A male asthmatic, age 54, with considerable fibrosis and some emphysema had an acute pneumonic process involving the right mid-lung area. Two months later x-ray revealed a large cavity. Of 40 sputum cultures, 14 were positive for Group II unclassified Mycobacteria, and some very heavily positive. All were negative for M. tuberculosis.

3.—A girl, age two, had chronic cervical lymphadenitis with suppuration. Group II organisms were isolated from seven cultures of purulent exudate over a three month period.

4.—On x-ray survey in 1958, a white male, age 60, was found to have pulmonary disease with cavitation. The sputum was heavily positive for unclassified Mycobacterium (Group III) and always negative for M. tuberculosis. The disease progressed despite active antituberculosis drug therapy, eventually involving the whole left lung. In 1962 death resulted from massive pulmonary hemorrhage.

5.—In August 1962, a colored female, age 36, was found radiologically to have extensive disease of the left lung and was hospitalized. Sputum cultures were repeatedly positive for unclassified Mycobacterium Group IV

and negative for M. tuberculosis. After 12 months the patient is still in the hospital.

Clinical observations, therefore, reveal the widest ranges in both the nature of the individual reaction and the severity of pathological change due to the different groups of unclassified Mycobacteria. Though Groups I and III as well as Groups II and IV are found in the absence of any detected pathological process, nevertheless, in some hosts, all organisms appear to act as potent pathogens. This behavior is usual for Group I infections, and it is not uncommon for Group III. Occasionally Group IV appears as a primary pathogen while Group II assumes this role rarely, and then usually in nonpulmonary localized infections.

Summary

Current evidence indicates that infections due to unclassified Mycobacteria are of definite public health significance in Florida. Of those affected, males outnumber females two or three to one. Rural dwellers are involved more than urban residents. Cases occur sporadically without evidence of man to man spread. The organisms appear to be widely available in some nonhuman source. Epidemiological and laboratory findings indicate that the most probable source is soil. Admittedly more evidence on these points is needed and is being accumulated gradually.

In 60 per cent of all persons with cultures positive for unclassified Mycobacteria, the cultures yielded Group III organisms. Our records include a substantial series of clinically severe cases in which all evidence pointed to the Group III organism as the primary pathogen. But there are even more cases with cultures positive for this organism in which there is no clear evidence that it has any clinical significance. These seemingly less important cases tend to be neglected in follow-up, but they can be of high importance if the long term significance of infestation with these organisms is to be determined. We recommend the collection of a repeat series of three samples after an initial positive culture, and if these are negative, to repeat this procedure one year later. It is important to be alert for new clinical manifestations in such cases, and to record and report both positive and negative observations. Prolonged follow-up of cases with single positive findings is not suggested. Simple findings, which mean little in a single case, can become highly significant when recorded, analyzed and interpreted in a series of cases occurring throughout the state.

It is our recommendation, henceforth, that the follow-up of these unclassified infections be more selective. We have reviewed our cases separating the minority, which need further study and follow-up, from the majority, which need further attention only if new clinical manifestations appear. It is our hope that fewer cases may receive more adequate and meaningful attention. The more significant minority of cases with cultures repeatedly positive for unclassified Mycobacteria need to be followed as are active tuberculosis cases with the submission of sputum specimens monthly. Also, we urgently wish to obtain at least brief initial information on all cases in which cultures are newly positive for any one of the groups of unclassified Mycobacteria.

In one other area, advancement of knowledge calls for understanding cooperation. Further tuberculin testing using two antigens is indicated with repeat testing in a substantial series of school children with high reaction rates.

The study of infections due to unclassified Mycobacteria in Florida was initiated as a cooperative study between the Bureau of Laboratories and the Tuberculosis Hospitals. In the central office of the State Board of Health, it has extended to involve the divisions of epidemiology and tuberculosis of the Bureau of Preventable Diseases. It is increasingly apparent that the current need is for expanded field studies. We solicit even more intimate cooperation in the study of this important and fascinating group of infections.

Contractions are the order of the day since we are living in a lazy world. Methyl and ephedrine could be Methedrine, a very effective product made by Burroughs Wellcome, advertised on page 673.

President's Page

Responsibility — Work, Donate, Vote!

Our nation was founded on a principle of individual freedom. Our founding fathers believed in government *of* and *for* the people but not *by* the people. It remained for Jackson to promote equalitarianism as the dominant theme of our land. Only then did the rule of the majority become absolute.

The vote of each qualified American counts the same as that of any other. Standards for registration as a voter have been lowered until only physical age or a complete inability to read and write now holds one back. Mental age, responsibility, loyalty to country are not considered. One wonders how long physical age and illiteracy will stand in the way since many in these groups are better able to exercise the prerogative of an intelligent vote than many who already qualify.

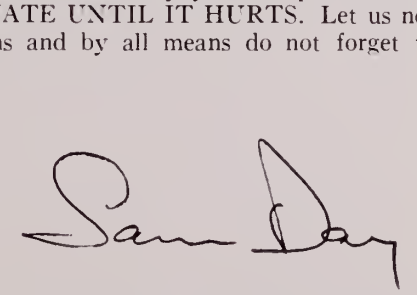
Many of us feel very strongly that with each right should go a responsibility. Each voter should be a responsible individual who attaches considered importance to his vote. But how is one to decide just who will qualify under these standards? Should the party in power at the time take this authority? I think not. Who are we to decree the rules by which some will have this right eliminated? No group in America is completely united in its thinking on any issue. Very likely it remains that way as long as individual initiative is a dominant feature of our people—and we hope that will be a long, long time.

What then are the "responsible" citizens of our land to do? I say they are to provide leadership for those of our people who need to be and expect to be led. There is a great need in our world for honest, forthright leaders today. We, in medicine, have an opportunity to help, but can any deny that we have neglected these responsibilities thus far?

Justice Oliver Wendell Holmes wrote, "Life is like an artichoke. Each day, each week, month, year, gives you one little bite which you nibble off, but precious little compared to what you throw away." Think a minute, how much do *we* physicians nibble off? Over 2,000,000 people pass through our offices each day. What an opportunity to exercise leadership, through words, through examples, of many who want to be led. Not only do we throw away our opportunities to influence people, but too often we also neglect our own right to vote—an unpardonable oversight.

Democracy and individual freedom may not be the best form of government for us BUT no one has shown us a better one. Many have tried, but communism, socialism and other idealistic methods have not succeeded as well as we. One basic item—the unlimited thinking of the human mind with basic selfishness, assures the eventual defeat of all totalitarian states regardless of their motives.

We have been faced with the loss of our freedom to practice medicine as we know it. Few, if any, doctors have exhausted their efforts toward defeating this issue. We are faced with important elections on November 3. Candidates of our choice need help, financial and physical help. The time is short. Let us WORK WITH RENEWED EFFORT, DONATE UNTIL IT HURTS. Let us not throw away another opportunity. See to it that our man wins and by all means do not forget to "nibble" on the third—VOTE!



P.S. My wife Dolly suggests that if you do not plan to vote right, just disregard what I have said.



Ear Banks and Research

The etiology and pathogenesis of many cases of deafness remain obscure because of the difficulty in studying the delicate inner ear structures. The usual techniques of correlating antemortem and preoperative findings with surgical specimens or postmortem findings are not satisfactory because of anatomic peculiarities of the inner ear. Its delicate soft structures are encased in solid eburnated bone and suffer severe autolytic and artifactual changes when ordinary histologic processes are utilized. In addition, many cases of deafness are congenital or occur in early life and the ear is not available to histologic study until 60 or 70 years later. Furthermore, deafness is a symptom and a sign and rarely or never results in death. Hearing impairment is ordinarily a minor consideration at that time and is consequently forgotten as deaf people succumb to other illnesses.

Recent advances in sophisticated audiologic techniques in evaluating hearing losses and in microscopic middle ear surgery for the improvement of hearing have restored serviceable, unaided hearing to thousands of hard of hearing patients and at the same time advanced the knowledge of the pathogenesis of many types of conductive hearing losses. In these patients, the middle ear structures can be examined directly under the operating microscope. These advances have stimulated and renewed the interest of otologists in basic factors responsible for sensorineural (nerve) deafness. With the exception of a few isolated instances, medical science has thus far been powerless to aid persons so afflicted. There exists now, however, a satisfactory mechanism for gathering this vital information.

The Temporal Bone Banks program was established some six years ago under the sponsorship of the American Academy of Ophthalmology and Otolaryngology with the support of the Deafness Research Foundation. This latter organization was founded in 1958 by Mrs. Colette Ramsey, whose hearing was restored by surgical means. Its sole purpose is the support of research into the causes of deafness. The Temporal Bone Banks program consists of a Center in Chicago with a network of some 30 banks set up in universities and hospitals throughout the country. These are equipped to procure, process and study the temporal bones of all patients with documented hearing losses, vestibular disturbances, facial nerve paralyses, and any other disease of the temporal bone structures. Florida has two such banks, one at the University of Miami School of Medicine in Miami and the other at the University of Florida College of Medicine in Gainesville.

The Center furnishes full directions as to the procedure necessary for the pledging of temporal bones and the legal forms which must be completed. These are also available from any bank and many hospitals and otologists. Pledges are secured from appropriate patients who then carry identification cards giving written permission to remove the temporal bones at the time of death and instructions to telephone collect to the Center for complete details. Complete records of each donor are maintained in the Chicago Center which is notified by telephone upon the death of the donor. The temporal bones are then secured and processed in one of the cooperating laboratories and complete histopathologic studies correlated with the antemortem clinical information.

It is apparent that this program is very ambitious and is necessarily an extremely long range project. Progress will be slow and results will be directly proportional to the number of temporal bones pledged. For this reason, a plea is made for the cooperation of all physicians and their hard of hearing patients in the state of Florida. Detailed information and necessary forms can be obtained from Dr. James R. Chandler in Miami or Dr. George T. Singleton in Gainesville.

James R. Chandler, M.D.
Miami

Facilities for the Treatment of the Mentally Ill

The magnitude and the seriousness of the mental health problem have led to the realization on a national level that there is a desperate shortage of both trained personnel and adequate facilities for the treatment of the mentally ill. One approach to the solution of the personnel shortage was presented in a previous paper on the creation of a helping profession of psychotherapy.

In considering the problem of adequate and suitable facilities for the treatment of the mentally ill, one must remember that modern man evolved from a very primitive form of life over one billion years ago. The environment of this primitive form of life was different from the environment that evolved concomitantly with man.

This environment has both physical and psychical components. Man can function effectively if at all only in the environment that evolved with his own development. This was dramatically emphasized in recent times with man's venture into space in which the first prerequisite was the construction of a vehicle which would enable man to take his environment with him. Without this, he would perish.

Man's psychic evolution from the horde to the uniquely individual human being has manifested itself in the importance of the small group, especially the family. Without a psychic environment with small group characteristics, man cannot function effectively and is more prone to mental illness.

The awareness of these factors has led to a reappraisal of the usefulness of the large state mental hospital and to a shift to small community mental health centers.

The following recommendations of the Joint Commission on Mental Illness and Health reflect the need for smaller treatment centers:

> Therefore, a national mental health program should set as an objective one fully staffed, full time mental health clinic to each 50,000 of population.
>
> No community general hospital should be regarded as rendering a complete service unless it accepts mental patients for short term hospitalization and therefore provides a psychiatric unit or psychiatric beds.
>
> Smaller State hospitals, of 1,000 beds or less and suitably located for regional service, should be converted as rapidly as possible into intensive treatment centers.
>
> No further State hospitals of more than 1,000 beds should be built, and not one patient should be added to any existing mental hospital already housing 1,000 or more patients.

To begin to implement these recommendations, the United States Senate, in June 1963, passed a bill for the expenditure of 847 million dollars over 10 years to help construct and staff community mental health centers.

There is also an urgent need, especially for children and young adults, for numerous small residential treatment centers where the therapeutic environment would resemble the uniquely human home instead of the large dehumanized institution.

As physicians, inextricably bound to the care of the mentally ill, to the establishment of which of these facilities shall we lend our support?

The answer to this problem was stated clearly in the Report of the Joint Commission:

"In the matter of establishing priorities as they relate to the broad areas of patient care, recruitment, professional education and research in mental health, we would sound a note of caution. In the final analysis, our judgment warns us against imposition of a system of priorities. The reason is that we actually have no choice, as humanitarians as well as educators and scientists, but to move as rapidly as possible on all fronts at once."

Louis Alper, M.D.
Miami

Home Away From Home for Asthmatic Children

Allergists in the Miami area have long recognized the need for a residential treatment center dedicated to the long term inpatient care of children with severe and intractable asthma. There has been no such facility in the state of Florida or in the entire southeastern United States. It has been necessary to send children to institutions in Denver or Tucson where, every year, there are six to 15 children from Florida.

It is generally conceded among allergists that these children derive benefits from the supervised domiciliary care and the continued general and specialized medical care, rather than from the change in climate. Repeated reports from presently operating institutions in various parts of the United States indicate that a large percentage of the children responds well to treatment and becomes rehabilitated when they are removed from their own homes to a "home away from home."

In cooperation with the nonprofit National Asthmatic Children's Foundation, the Miami allergists and interested local laymen have established the Asthmatic Children's Foundation of Florida to operate the new residential treatment center in North Miami Beach at 1801 N.E. 168th Street. The Miami area physicians have organized themselves into a medical staff with a medical advisory board consisting of Dr. Nelson Zivitz, chairman, and Drs. James H. Putman, Meyer B. Marks, Morton L. Hammond and Jack A. Rudolph as members. The members of the advisory board, attending staff and consulting staff serve without remuneration.

The Foundation has as its philosophy the total environmental care of the child — physical, medical, climatic, allergic and psychological— without encouraging the concept that any single part of this spectrum is the dominant factor. Children with severe or intractable asthma are eligible for admission between the ages of six and 16 years, regardless of race, creed or color, who have failed to respond to modern allergy management after one year or who, after lesser treatment, are shown to have an illness that is sufficiently severe or progressive to warrant admission. As a member of the National Asthmatic Children's Foundation, the Florida organization will be able to participate in the transfer of patients from one geographic location to another when improvement is not obtained at a given residential center. Every effort is made to encourage normal living conditions with regard to attendance at public or religious schools, religious services, physical education programs within the capacity of each child, diet, and other factors. Based on the experience of similar institutions, the residential staff includes a registered nurse on duty at all times, a house mother for each 10 children, a cook, maid, and whatever additional personnel is needed to maintain the building, grounds, laundry, mending, and other requirements. Of course, medical care is immediately available.

The cost of operation of this residential center is the full responsibility of the Asthmatic Children's Foundation and funds are largely obtained by mail solicitation. No fee will be charged for any service rendered except where covered by hospital insurance. Patients who can afford to do so will be expected to make contributions to the center, but this consideration will not be a condition precedent to the admission of any child. To the extent that it is possible, the policy is to admit children from varied economic and social backgrounds, without a preponderance of any group.

Correspondence regarding admissions may be addressed to the Admission Office, Asthmatic Children's Foundation, 420 Lincoln Road Mall, Miami Beach, Fla. 33139.

Nelson Zivitz, M.D.
Miami Beach

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Association News

Medical Affairs at the University of Florida

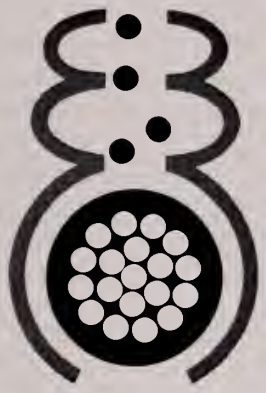
Representing the Council on Medical Education and Hospitals Drs. Emmet F. Ferguson Jr., James T. Cook Jr., J. Maxey Dell Jr., Donald R. Hagel, David R. Moomaw and Hugh A. Carithers visited the University of Florida College of Medicine on April 1, 1964. It is believed that the visit demonstrated to Dean George T. Harrell and a considerable number of the faculty that Florida physicians are interested in their medical school. Concurrently, the Committee in joint meetings and in visits to major clinical departments learned many facts that should be of interest.

Bed Utilization

Of the 385 beds available and equipped, some are not in use because of lack of funds. There exists much misunderstanding among referring physicians as to the reason that the hospital cannot accept all indigent patients referred. Most departments would like to admit more if they could. Funds acquired recently for 10 clinical research beds help a little, but these beds must be used for research projects previously approved and cannot be used simply to render routine patient care. Through county subsidy, Crippled Children Funds, a National Foundation grant, and other such funds, some departments, notably obstetrics and pediatrics, do have a considerable number of indigent patients. An enabling law passed by the legislature for funds to allow diagnostic work-ups on an outpatient basis has never been implemented because of lack of appropriations. All local indigent emergencies are transferred to the Alachua County Hospital as soon as possible. This practice creates problems for town doctors.

Hospital Expansion

Half a million dollars has been appropriated by the legislature for the construction of an inpatient psychiatric unit for children. This money will be used for matching a proposed grant for one million dollars of federal funds to construct a Human Development Center. Another half million dollars will be sought from other sources and will allow the development of a center for the study of growth and development, congenital defects and teratology. This is envisioned as a training center for medical personnel as well as research.



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diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.

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dosage:

The recommended initial *adult* dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months, to 10 mg. for one 8 to 12 years of age.

cautions and side effects:

Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE

Research in the Service of Medicine

Ground is being cleared for the construction of a new Veterans Hospital across Archer Road from the medical school. This will have 240 psychiatric beds and 240 general medicine and surgical beds. The relationship between the College of Medicine and the new hospital is still not completely defined, but part of the hospital will be used for teaching purposes under a Dean's Committee. The staffing of the new hospital with nurses, technicians and other personnel will seriously affect the Alachua County Hospital, the medical school, teaching hospital and even more distant areas such as Jacksonville, as Veterans Administration salaries are usually higher than in other hospitals.

Students

The Committee was impressed with the care taken in the selection of approximately 60 freshmen each year. There were 369 applications received for the class of 1966, 402 for the class of 1967, and 533 for the class of 1968. Never more than 15 per cent of out of state students have been accepted and the incoming class will have about 5 per cent. The University as a whole has about 12 per cent of out of state students. All applicants accepted have had personal interviews. For the current year, the student body of 204 is made up of 57 first year, 59 second year, 44 third year, and 44 fourth year students. It is too early to tell where graduates are settling and in what type of practice they will be engaged. Military training and residency work have allowed only a few of the first class of 1960 to begin practice. Eventual location and type of practice of graduates will be studied and tabulated by school officials.

The school has a faculty member as internship advisor and each class in the clinical years has its own advisor, who may also be consulted regarding internships. Graduates are advised not to stay at the medical center for their internships, but since from one fourth to one third of first year and three fourths of fourth year students are married and many of the wives have good jobs in the University, many do not wish to leave. Of the first three classes graduated, only 39 of 123 elected to intern in Florida and of these 21 stayed at the medical center.

There has been one Negro student in the school. She failed the second semester of her first year. Her record has been reviewed by a group interested in Negro advancement.

School Expansion

An increase in the number of medical students in the near future is apparently impossible due to lack of laboratory space for the first and second year students. The Dean believes that unless a dental school is established, at which time new laboratories would have to be built, expansion is impossible. He thinks that Florida will need another medical school in the future, but that a good one could not be in operation before 1975 as it takes about 10 years to plan, build and staff. He does not think that two year medical schools are the best solution to a possible doctor shortage, although he states that the Executive Council of the Association of American Colleges does approve of two year schools.

Town and Gown

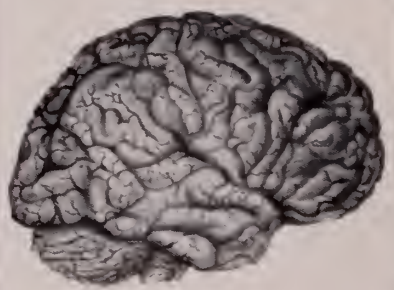
Relationship between full time faculty in a medical school and physicians practicing in the community in which it is located is usually a tenuous one, and the smaller the community the more delicate the balance. The Committee could not assess the relationship in Gainesville. A liaison committee between school and practicing physicians exists, but has not met in over a year. A member of the faculty of the College of Medicine is president-elect of the Alachua County Medical Society.

The Committee believes that in the University of Florida College of Medicine we have an excellent school which is executing its mission and that its future, which is bright, should be a continuing concern of Florida's physicians.

Hugh A. Carithers, M.D., Chairman
Council on Medical Education and Hospitals, Jacksonville

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News

The 18th Clinical Convention of the American Medical Association will be held at Miami Beach November 29-December 2. The entire scientific program, with the exception of the fireside conferences and breakfast roundtables, is scheduled in the Miami Beach Convention Hall. The complete program plus forms for advance registration and hotel accommodations may be found in the October 26 A.M.A. Journal.

The annual meeting of the American Society of Anesthesiologists is being held in the Americana Hotel at Bal Harbour on October 10-14. Dr. George H. Mix of Melbourne is chairman of the local arrangements committee.

The Second Annual Seminar in Cardiology, "Diagnostic Methods in Cardiology," will be held at the Tampa General Hospital in Tampa, December 3-6.

The meeting of District IV of the American College of Obstetricians and Gynecologists is being held in the Hotel Robert Meyer in Jacksonville on October 1-3.

Meetings

October

Cardiovascular Seminar, October 9-10, Room M-112, Medical Sciences Building, University of Florida College of Medicine, Gainesville

"Modern Concepts of Nutrition and Heart Disease," October 22-24, Mound Park Hospital Auditorium, St. Petersburg

Florida Society of Anesthesiologists, October 10, Hotel Singapore, Miami Beach

American Society of Anesthesiologists, Annual Meeting, October 10-14, Americana Hotel, Bal Harbour, Fla.

Seminar in the Diagnosis and Treatment of Anxiety and Depression, October 14, St. Vincent's Hospital, Jacksonville.

Florida Psychiatric Society, Fall Meeting, October 24-25, Palm Beach Towers, Palm Beach, Fla.

Florida Academy of General Practice, Fifteenth Annual Scientific Assembly, October 29-November 1, Yankee Clipper Hotel, Fort Lauderdale

November

Southeastern States Cancer Seminar, November 11-12, Hotel Robert Meyer, Jacksonville

Florida Pediatric Society, Annual Fall Meeting, November 12-14, Colony Beach Resort, Sarasota

Florida Urological Society, Fall Meeting, November 13-14, Parliament House, Clearwater Beach.

American Medical Association, Clinical Convention, November 29-December 2, Americana Hotel, Bal Harbour

December

Second Annual Seminar in Cardiology, "Diagnostic Methods in Cardiology," December 3-6, Tampa General Hospital, Tampa.

Seminar in the Present Status of Amputation Surgery and Prosthetics, December 3-5, Americana Hotel, Bal Harbour, Fla.



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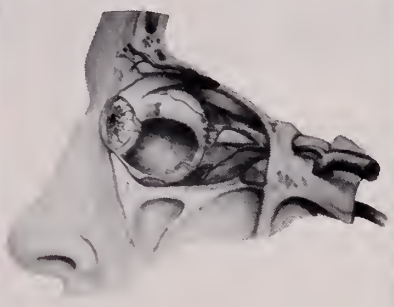
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Meyer B. Marks, M.D.
James H. Putman, M.D.
Jack A. Rudolph, M.D.
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Correspondence should be addressed to:

Asthmatic Children's Foundation of Florida
420 Lincoln Road Mall
Miami Beach, Florida 33139

* Affiliate of the Asthmatic Children's Foundation
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WANTED: Pediatrician for association with two obstetricians. Office space, basic equipment and guaranteed income are available for an acceptable man. Write 69-551, P.O. Box 2411, Jacksonville, Fla.

WANTED: General Practitioner for Clinic-Hospital. Salary open—plus bonus. Write 69-535, P.O. Box 2411, Jacksonville, Fla.

OBSTETRICIAN - GYNECOLOGIST WANTED: To associate with two man group. Large established practice in Miami; Board eligible or certified; prefer under age 35. Write P.O. Box 384, Miami Shores, Fla.

FOR IMMEDIATE SALE: Combination, well established Miami Beach medical practice plus successful next-door optical business as a unit. Will sacrifice. Write 69-593, P.O. Box 2411, Jacksonville, Fla.

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WANTED: General Practitioner to join established GP in university town NW Florida. Guaranteed salary leading to full partnership. Prefer doctor who is unmarried and under 35. Write Box 612, Tallahassee, Fla.

WANTED: General Practitioner with surgical training or general surgeon willing to do some general practice for association in established central Florida practice. Attractive location and facilities. Write 69-604, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER WANTED: in small northwest Florida town. 33 bed private hospital. Physician departing for industrial position and associate seeking replacement. Excellent opportunity in farming-industrial area. Contact R. O. Mills, Adm., P.O. Box 183, Century, Fla.

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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).



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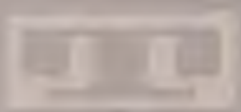
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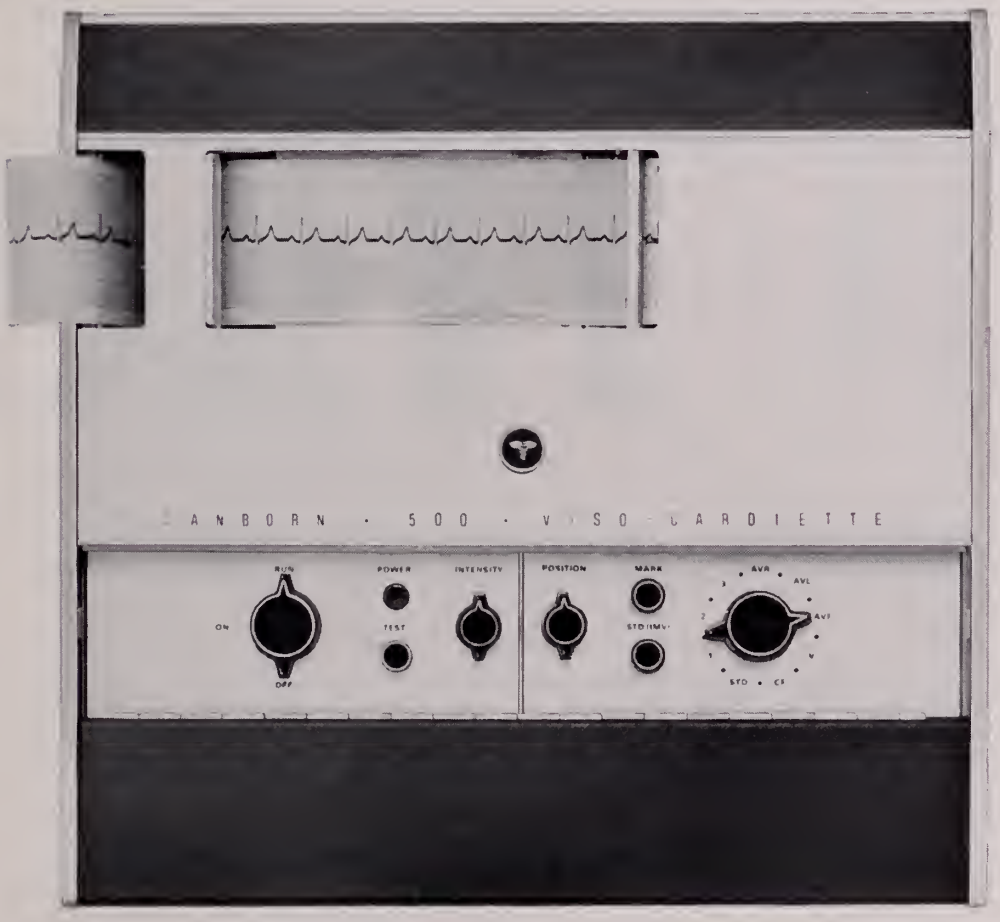


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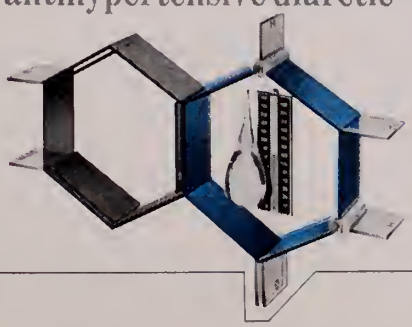


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1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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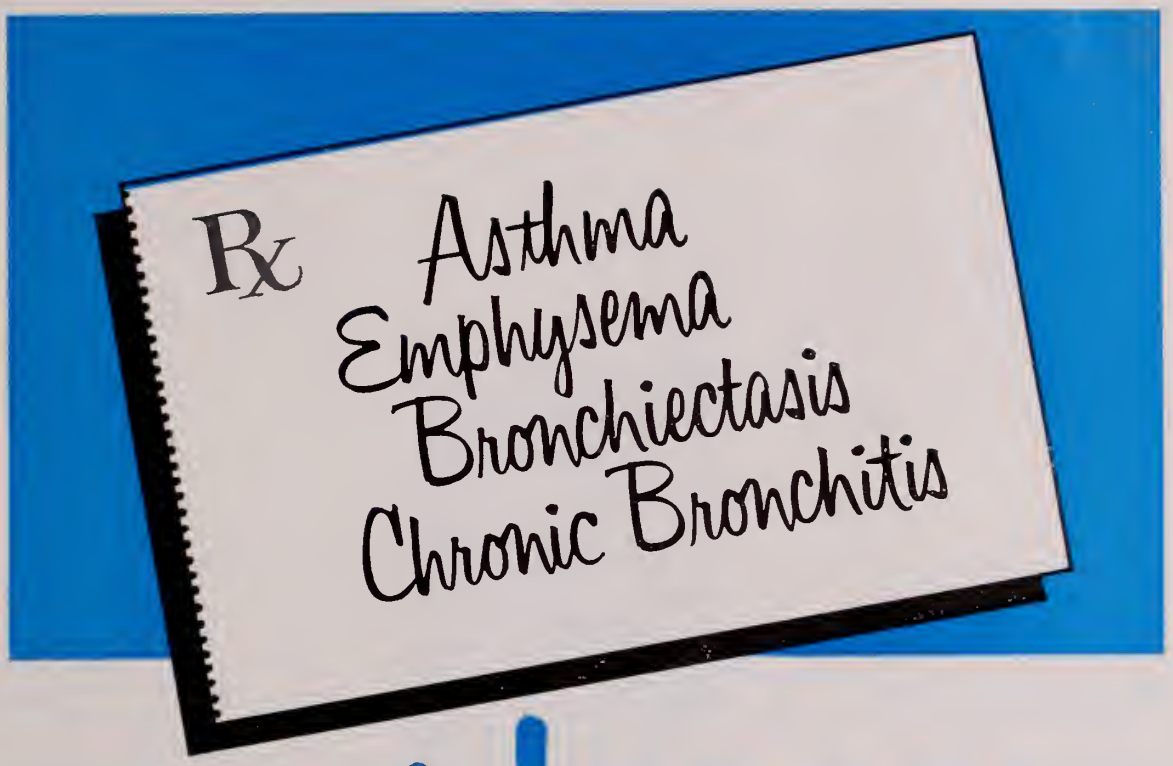
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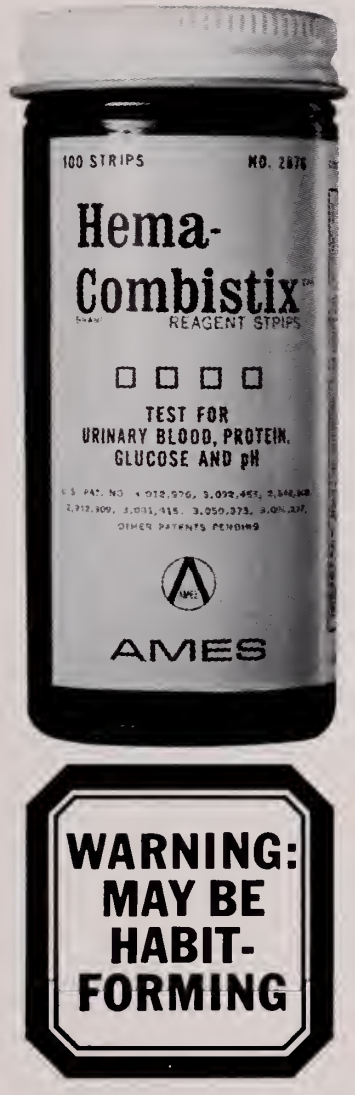
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Alcoholism: As an aid in symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis	10 mg, 3 or 4 times during the first 24 hours; reducing to 5 mg, 3 or 4 times daily as needed
Muscle spasm associated with cerebral palsy or athetosis	2 mg to 10 mg, 3 or 4 times daily

Contraindications: Valium (diazepam) is contraindicated in infants, patients with a history of convulsive disorders or patients with a history of glaucoma.

Warning: Valium (diazepam) is not of value in dealing with psychotic patients manifesting anxiety and should be avoided when there is reason to believe the patient is psychotic.

Precautions: In elderly or debilitated patients, it is important to limit the dosage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, to be increased gradually as needed and tolerated). As is true of all CNS-acting drugs, until the correct maintenance dosage is established, patients receiving Valium (diazepam) should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving an automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam)—particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

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Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (*e.g.*, convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

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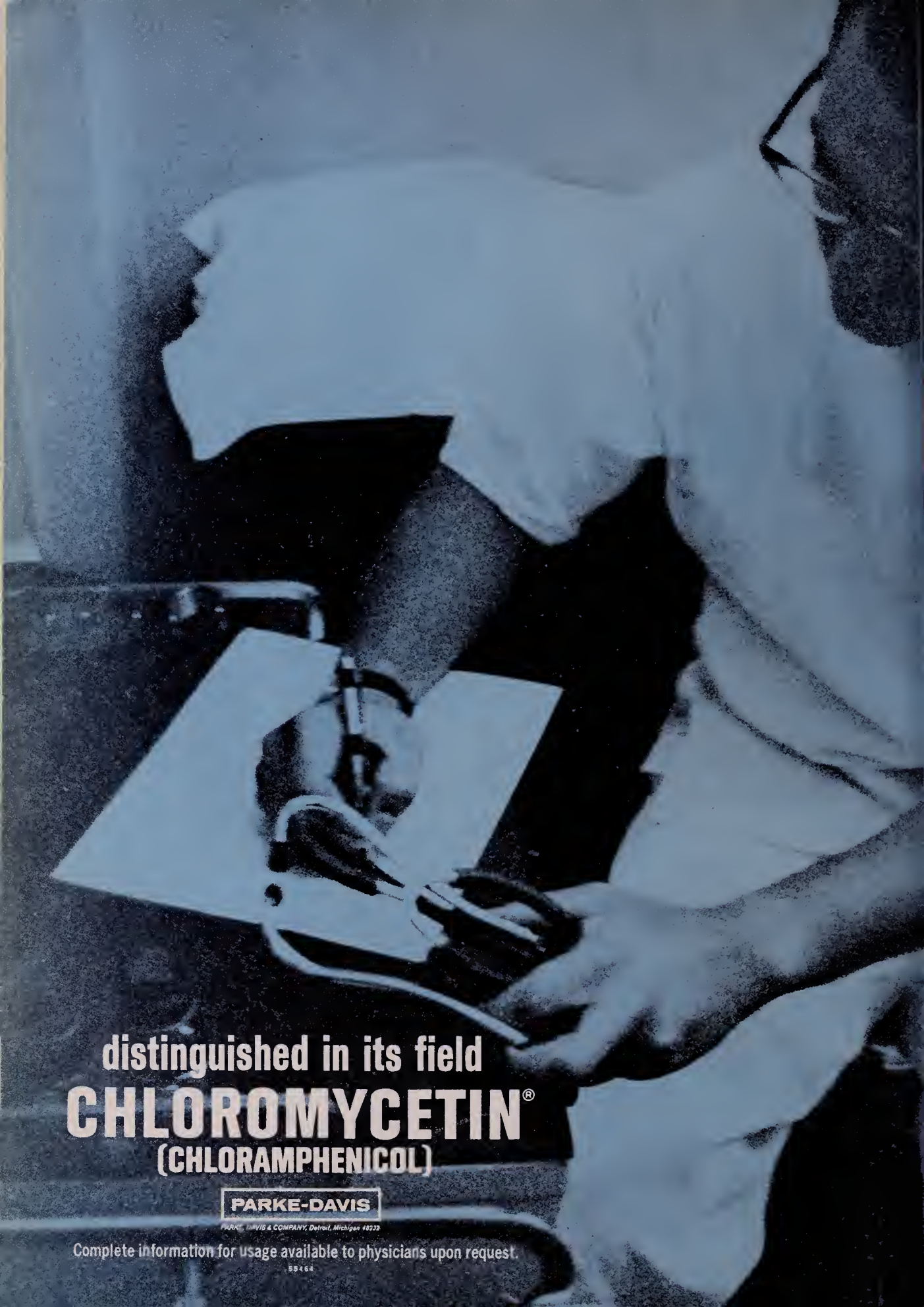
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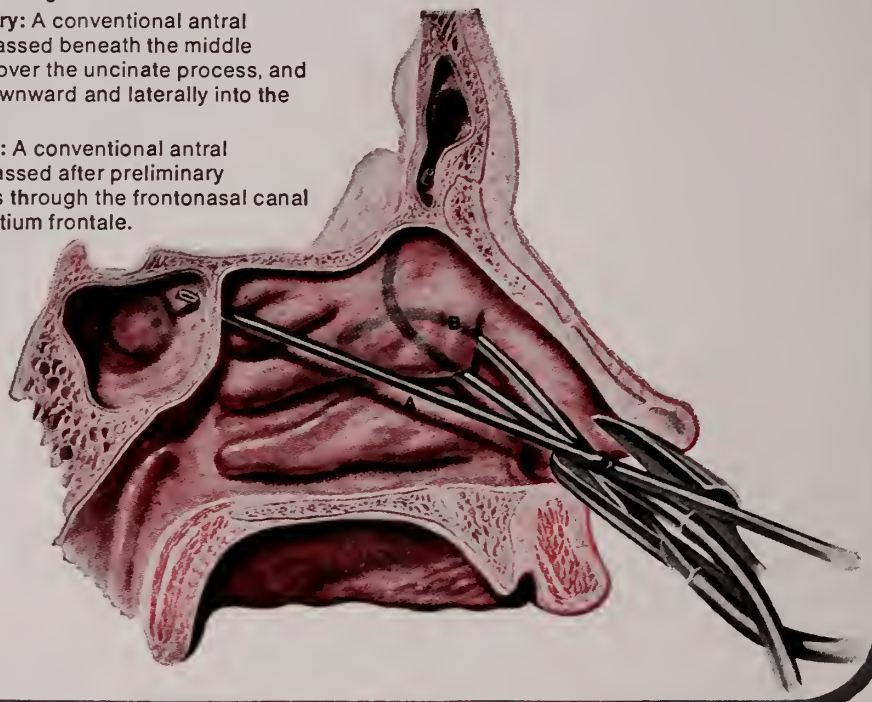
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*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

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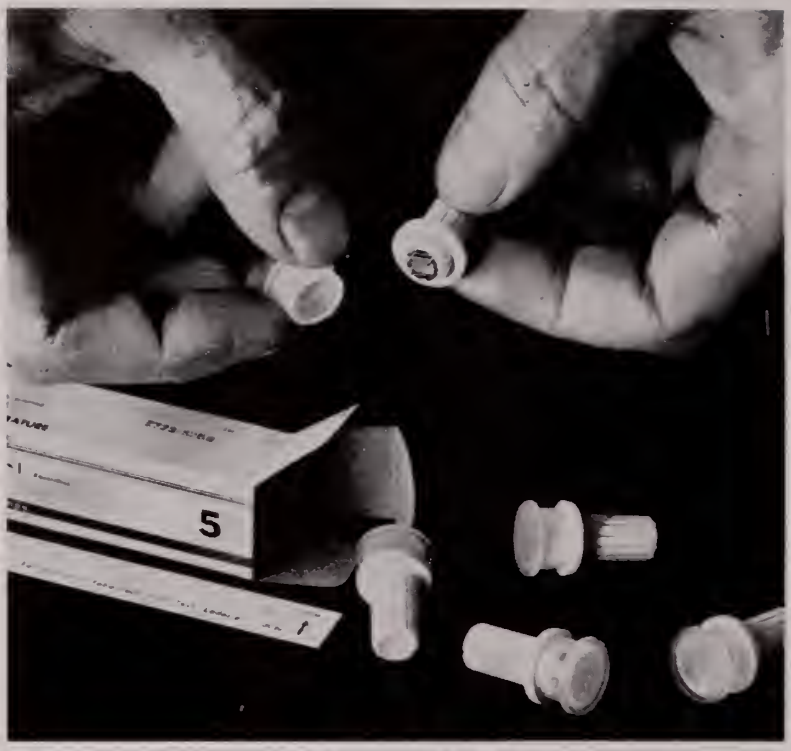
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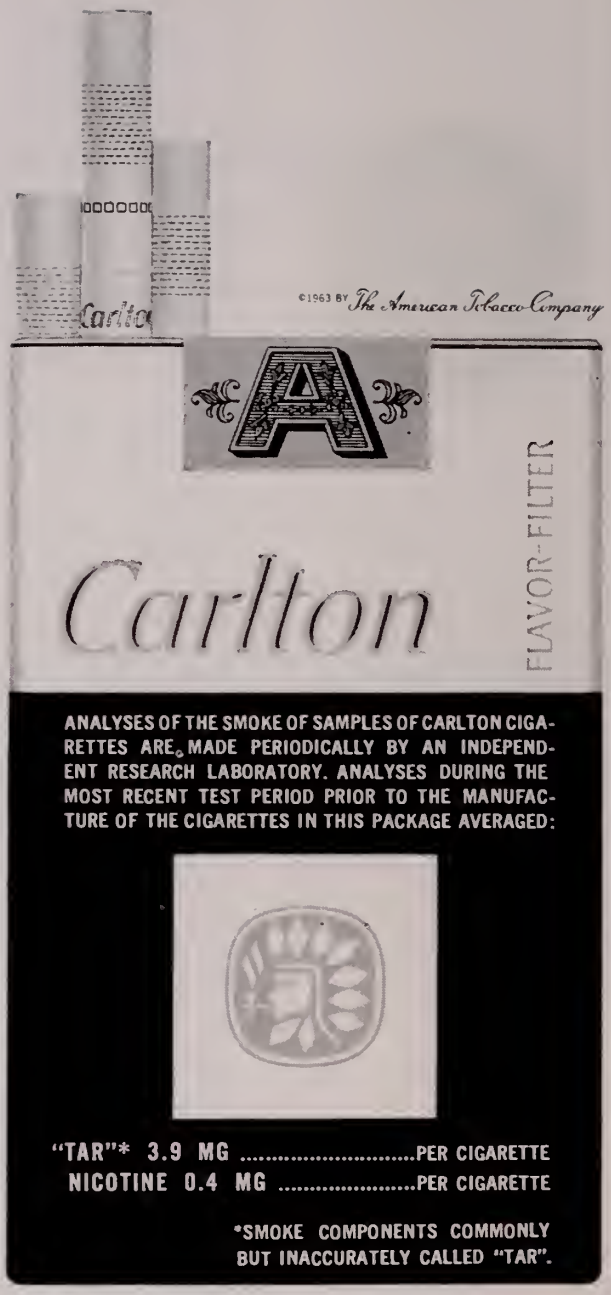
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Of 1,088 patients with confirmed skin and soft-tissue infections... 1,036 or 95.2% were treated successfully with Signemycin®

Note:
Morador et al.* obtained *excellent results in the treatment of 185 out of 191 soft-tissue infections,* all due to staphylococci. They state: "In the most serious infections occurring in patients with impaired resistance (mainly diabetics) we have had very good results in the control of the infectious condition." In these studies, incision and drainage were employed where indicated.

*Morador, J. L. et al.: Antibiot. Ann. 1959-1960:716.

Condition	No. of Patients	No. Cured with Signemycin
Abscesses, various	35	34
Abscess, gluteal or perianal	54	52
Burns, infected	331	307
Carbuncles and furuncles	125	122
Cellulitis	104	102
Lacerations and wounds, infected	142	128
Ulcers, infected	107	106
Various superficial infections	190	185
Totals	1,088	1,036 (95.2%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

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SIGNEMYCIN®

Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

More detailed professional information available on request.

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Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Cured with Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

consistently effective...often when others fail

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

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The HASKELL family of graduated analgesics . . . select the analgesic according to the degree of pain: HASAMAL—Formula above. HASACODE—Hasamal formula with ¼ gr. Codeine Phosphate, or HASACODE "STRONG"—Hasamal formula with ½ gr. Codeine Phosphate. (Warning: May be habit forming.) Narcotic order required for HASACODE and HASACODE "STRONG".

Dose: One or 2 tablets every 3 or 4 hours.

Contraindications: Do not use in patients with glaucoma or in elderly patients with prostatic hypertrophy.

Precautions: With therapeutic dose, usually no side actions are observed. However, in occasional patients, dryness of mouth, and blurred vision may be encountered. Should these symptoms occur, the dose should be reduced. Should soporific action or sedation be encountered, such patients should be cautioned against driving an automobile or operating machinery.

to relieve the discomforts of upper respiratory infections

- **relieve pain and tensions**
- **reduce fever**
- **stop excessive nasal secretions**
- **without unwanted diaphoresis**

(especially important for ambulant patients)

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Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

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Effective in peptic ulcer, intestinal colic, ileitis, esophageal spasm, spastic colon, alcohol-induced G.I. upsets, gastric hypermotility and anxiety neurosis with G.I. symptoms. Should be used as adjunct to other measures.

Side Effects (due to tridihexethyl chloride): dry mouth, blurring of vision, constipation.

Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention.

Also available, without phenobarbital, as PATHILON® Tridihexethyl chloride SEQUELS® 75 mg.

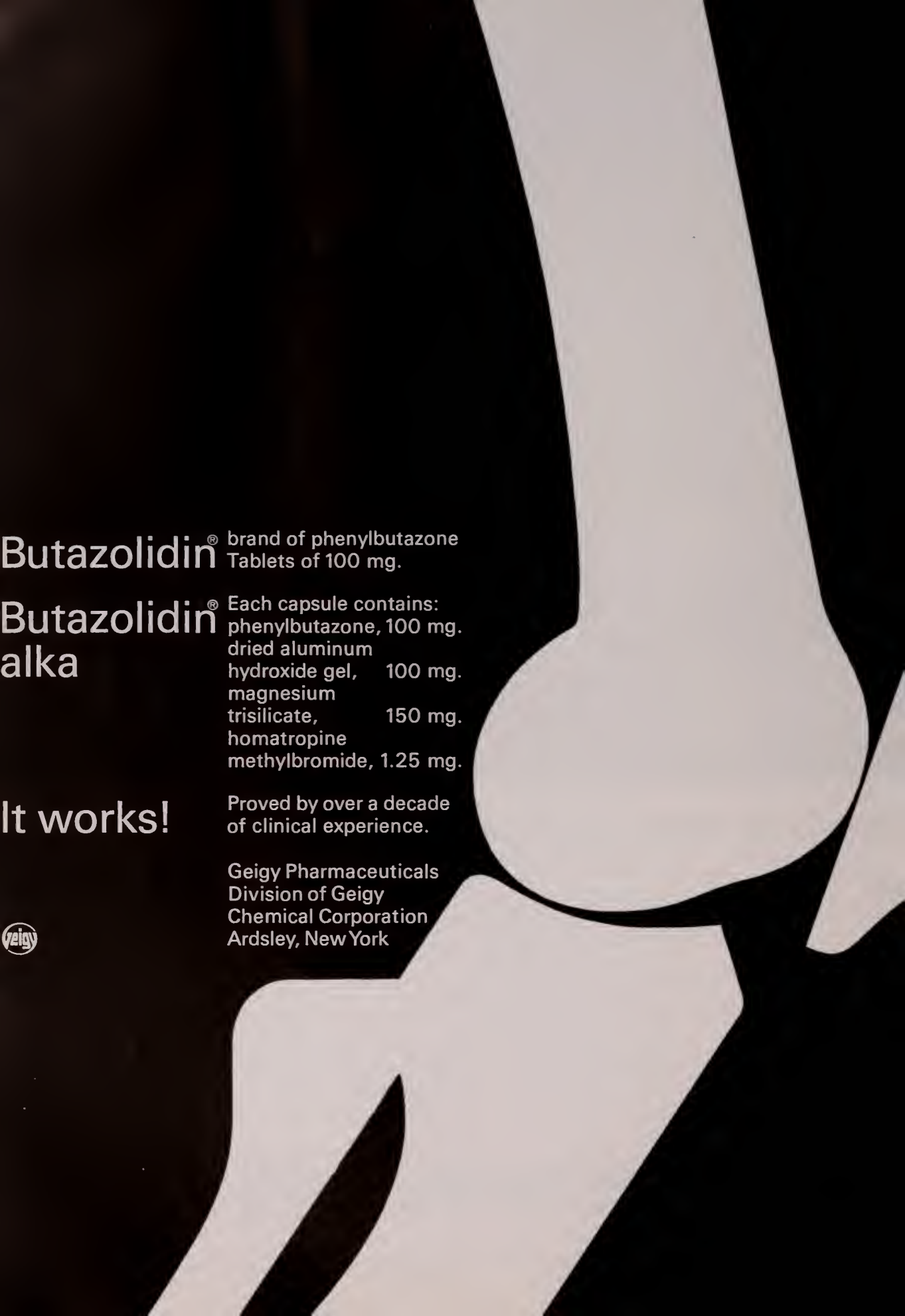
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Each capsule contains: Tridihexethyl chloride, 75 mg., and phenobarbital, 45 mg.

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Each capsule contains:
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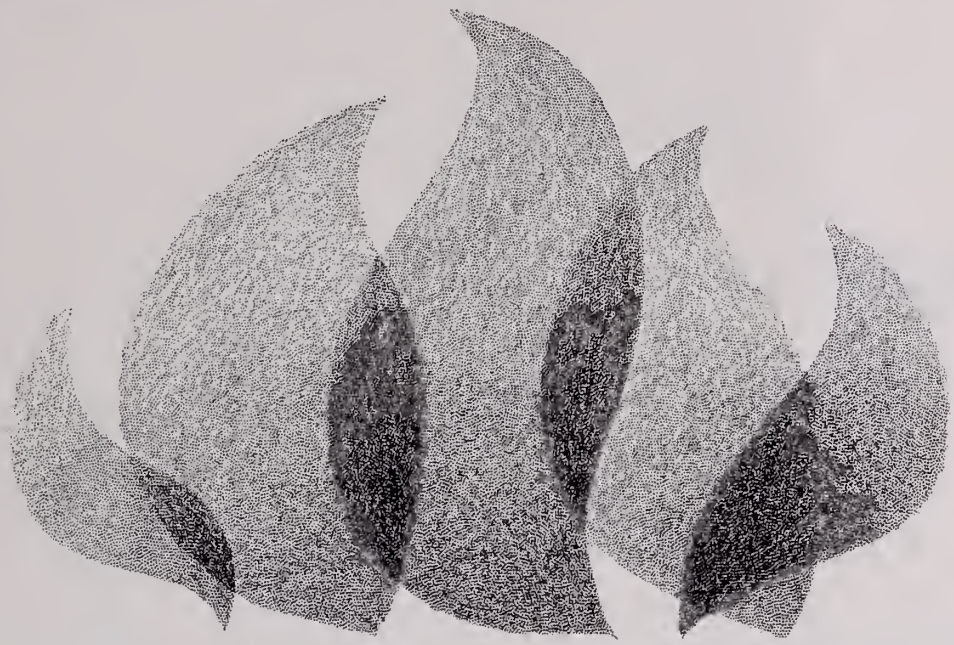
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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).



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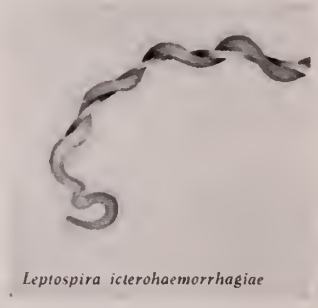
Effective against pathogens encountered daily...or rarely

Consistently reliable against common bacterial infections, Terramycin (oxytetracycline) meets the acid test of broad-spectrum effectiveness by scoring high in activity against many recalcitrant and less frequently encountered organisms as well. *Balantidium, Leptospira, Pseudomonas, Listeria, Shigella,* the vibrios—all are responsible for difficult-to-treat infections and many strains are susceptible to oxytetracycline.



Brucella melitensis

No other broad-spectrum antibiotic has been employed in such a wide variety of

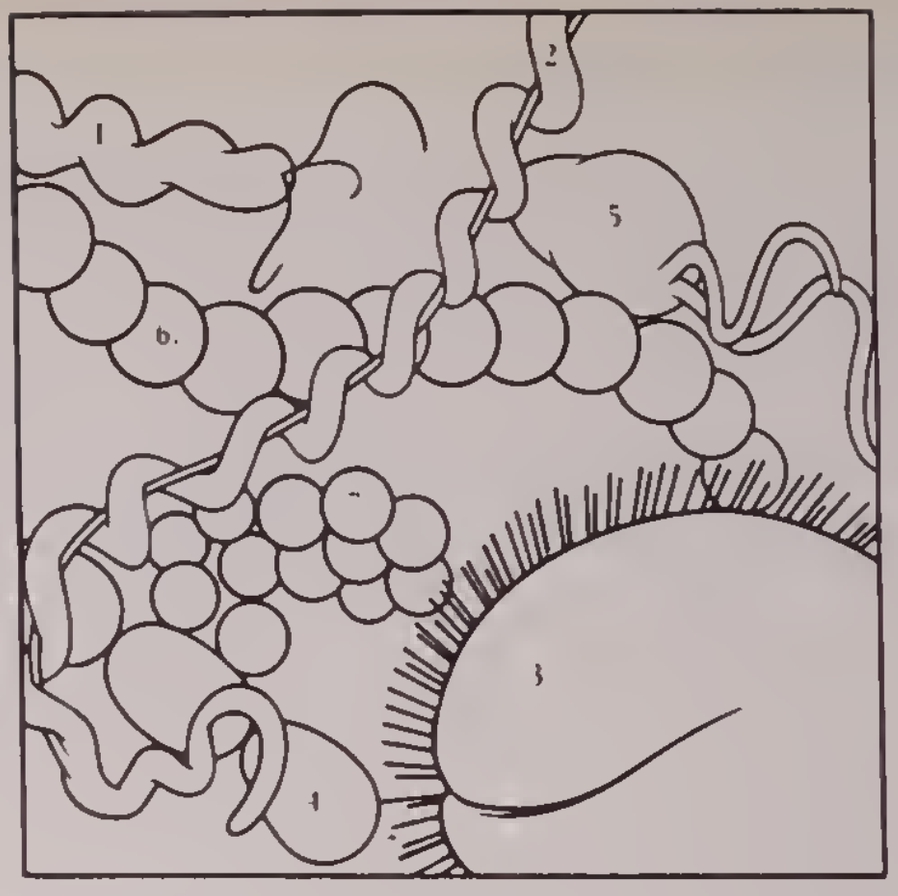


Leptospira icterohaemorrhagiae



The microorganisms shown here—ranging from common to rare and refractory—demonstrate the wide spectrum of Terramycin (oxytetracycline) effectiveness.

This three-dimensional sculptural rendition of microorganisms was based on photo micrographs.



Diagrammatic key to microorganisms

1. *Spirillum minus*
2. *Leptospira icterohaemorrhagiae*
3. *Balantidium coli*
4. *Brucella melitensis*
5. *Pseudomonas aeruginosa*
6. Streptococci
7. Staphylococci

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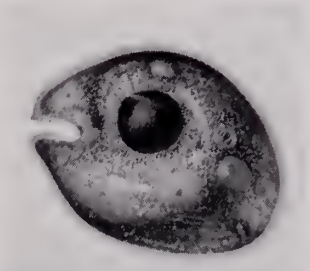
Streptococci Staphylococci

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Side effects: Glossitis and allergic reactions have been reported as rare side effects. Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth.

Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function, to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.



Balantidium coli

Precautions: Overgrowth of non-susceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated.

Formulas: Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg. Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc.

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oxytetracycline

unique properties make the difference in difficult or routine cases



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The JOURNAL
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Aspiration Biopsy

A Useful Tool in Cancer Diagnosis

Victor D. Dembrow, M.D.
MIAMI

Aspiration biopsy, as described by Martin and Ellis[1] in 1930, is a simple method of obtaining cellular material from an accessible tumor by means of needle puncture and syringe suction. A rapid diagnosis of cancer can be made, avoiding with considerable advantage an incisional biopsy. The earliest reference to this procedure in the American literature was made by Guthrie[2] in 1921, who reported two cases diagnosed by aspiration biopsy. One was Hodgkin's disease of a cervical node and the other a cervical node, metastatic from a nasopharyngeal carcinoma. Both were readily diagnosed from aspirated smears and he predicted widespread use of this clinical tool. Yet today, the method is still limited to medical centers familiar with its use and many pathologists and surgeons ignore its advantages. It is hoped that this paper will stimulate the more frequent use of a proved and valuable clinical aid.

History and Rationale

For the development of this technique we owe much to the pioneering efforts of Dr. Hayes E. Martin, who recognized the need for a rapid and simple method of cancer diagnosis. While he was working at Memorial Hospital in New York City, an institution devoted entirely to the care of cancer patients, this need became apparent from repeated patterns in the natural history of cancer. Dr. James Ewing, at that time Director of Pathology at Memorial Hospital, taught that natural barriers to the spread of cancer are set up by the body which are disrupted by the usual incisional biopsy techniques. He cited numerous examples of rapid dissemination of cancer following the disruption of these barriers.[1,6] It seemed reasonable that the small puncture wound in the tumor produced by aspiration biopsy would be less likely to cause this problem.

Ackerman and Wheat[3] stated that these observations are still pertinent. They cited the use of well planned aspiration biopsy to prevent contamination of operative fields. Excision of the needle tract with the definitive resection avoids the risk of implantation. An example of sarcoma of the upper end of the femur was described in which incisional biopsy produced spread of the tumor into tissue planes beyond reach of the disarticulation performed with hope for cure.

In the ensuing paragraphs the various applications of the aspiration biopsy in the management of the cancer patient are reviewed.

Interference With Regional Node Dissections

Many of Martin's cases were examples of the frequently encountered "lump in the neck." Often these represented metastases from an occult primary cancer in the nasopharynx, tonsil, base of the tongue or thyroid. The practice of radical neck dissection was being revived at Memorial Hospital in 1945 in an organized surgical program for the control of head and neck cancer. It became apparent that a clean, well executed neck dissection could not be performed after a previous excisional biopsy of a cervical lymph node. Such biopsies, frequently performed with poor exposure and through limited incisions, often resulted in fragmentary excision of the involved lymph node with dissemination of liquefied, necrotic cancer throughout the planes of the neck, reducing markedly the chances for later complete surgical resection.

Too often the appearance of such a node in the neck is the stimulus for an excisional biopsy rather than a careful search for a primary cancer in the head and neck area. Haste in excising a

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Fig. 1. — Hasty incisional biopsy without first searching for primary tumor. Primary cancer of the epiglottis.



Fig. 2. — Total laryngectomy and radical neck dissection. Spread of cancer in tissues of neck following incisional biopsy of cervical node.

suspicious node without first examining for a primary tumor is poor medical practice. Figure 1 is an example of such a hasty incisional biopsy. The patient presented with an asymptomatic mass in the left upper portion of the neck of three weeks' duration. The biopsy revealed metastatic squamous cancer which belatedly led to an examination of the oral cavity. A 1 cm. cancer of the epiglottis was found on mirror examination of the larynx and the patient was treated by total laryngectomy and left neck dissection. Figgure 2 shows the result of the incisional biopsy. Tumor is shown streaming through the sternomastoid muscle, released from its restraining capsule by the biopsy. Aspiration biopsy in this clinical setting readily establishes the diagnosis of the suspected metastatic squamous cancer. The primary tumor, if not found immediately on the first examination, is frequently discovered with more detailed and repeated examinations such as nasopharyngoscopy, indirect and direct laryngoscopy and cervical esophagoscopy. With both the primary tumor and its metastases discovered, a rational plan of combined therapy can then be pursued.

Fungation and Hemorrhage

Somatic soft part sarcomas and certain bone sarcomas often grow under great pressure by a restraining false capsule composed of fascial envelopments. This pressure produces central necrosis due to ischemia. Incisional biopsy may result in alarming hemorrhage and extrusion of necrotic tumor. The chagrined surgeon, unable to staunch the flow of blood or to contain the tumor, may be forced to pack the wound. Fungation of the tumor through a "simple biopsy wound" complicates the problem and makes definitive surgery more difficult. Figure 3 shows a 17 year old white male with a synovial sarcoma



Fig. 3. — Synovial sarcoma. Packing in incisional biopsy wound. Hemorrhage and fungation.

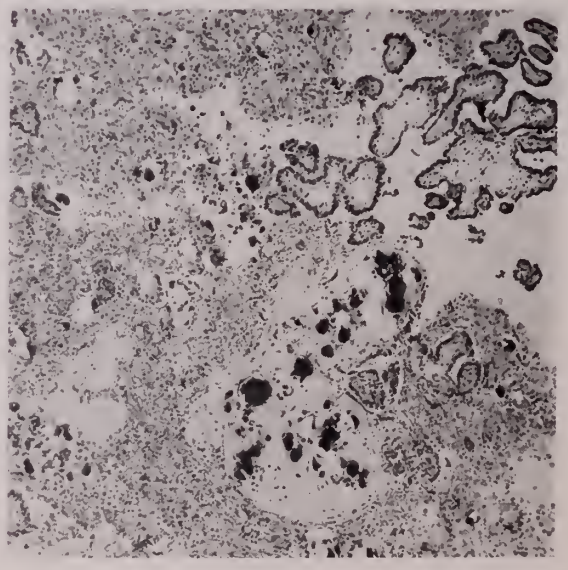


Fig. 4. — Aspiration "clot" (x80). Papillary cancer of thyroid in cervical lymph node—occult primary.

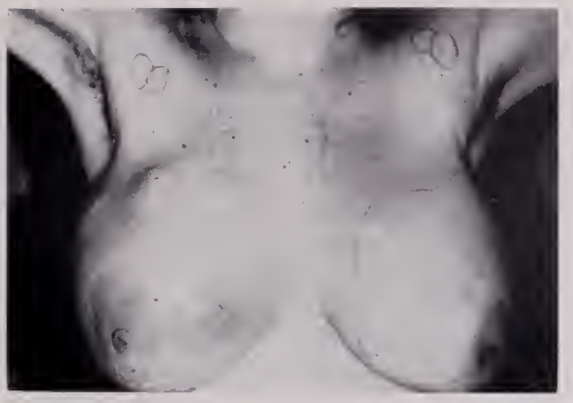


Fig. 5. — Advanced cancer of the breast. Documentation of diagnosis by aspiration biopsy.



Fig. 6. — Equipment for aspiration biopsy.

of the left hip. Two weeks prior, an attempted incisional biopsy resulted in this complication. He was referred for definitive treatment with a gauze packing in place surrounded by infected, fungating tumor. Aspiration biopsy would have established the presence of a malignant tumor and hemipelvectomy could have been offered earlier. The discomfort and delay produced by this complication could have been avoided.

Definitive Surgical Approach Based on Aspiration Biopsy

In many instances the surgeon, armed with the knowledge that cancer is present from the aspiration biopsy, is able to perform a definitive resection as a primary procedure. This may be preferred to cutting into the tumor to obtain preliminary material for frozen section. With increasing evidence that wound implantation is the result of poor technique,[3] the surgeon is obligated to reduce this hazard. Figure 4 shows an aspiration biopsy of an upper jugular lymph node that suddenly appeared in a 23 year old white male. Careful head and neck examination revealed no evidence of a primary tumor, but the node aspiration clearly showed metastatic papillary thyroid cancer. Note the well defined psammoma bodies, papillary fronds and the abundance of tissue obtained by this simple method. He was treated by radical neck dissection and hemithyroidectomy en bloc without contaminating the field by unnecessary incisional biopsy.

In my practice this approach has facilitated the rapid diagnosis of cancer not only in tumors of the head and neck area, but in somatic soft part sarcoma, bone sarcoma, Hodgkin's disease and reticulum cell sarcoma. It has proved useful during thoracotomy and celiotomy in obtaining tissue for diagnosis without gross contamination of the field with cancer cells. Cancer of the breast may be diagnosed accurately by this method and it is used routinely at Memorial Center in New York City.[5] In primary operable cancer of the breast, however, it has no particular advantage over the widely accepted frozen section except for some reduction in operating time. Kaae[4] discussed the dangers inherent in open breast biopsy



Fig. 7. — Infiltration of local anesthetic.



Fig. 8. — Puncture of aspiration site.



Fig. 9. — Aspiration of the tumor.



Fig. 10. — Collecting aspirate on blotting paper for "clot."

and questioned whether local recurrence is not occasionally due to wound contamination.

Documentation of Diagnosis

The literature is replete with instances of mistaken clinical diagnoses of cancer. Histologic proof of cancer is mandatory before any definitive therapy is undertaken. Yet frequently to obtain such proof by formal biopsy may seem academic. Such an example is the case of a far advanced cancer of the breast (fig. 5) with fixed axillary nodes precluding radical mastectomy. Before proceeding with x-ray therapy, aspiration biopsy confirmed the diagnosis and made the case suitable for later statistical and clinical analysis without disturbing the patient or incurring additional hospitalization expense.

Technique of Aspiration Biopsy

Equipment (fig. 6) is simple and readily available in most doctors' offices. It consists of a 30 cc. syringe, 2 cc. syringe, No. 25 needle, No. 18 needles (the new disposable needles are always sharp), 1 per cent lidocaine hydrochloride (Xylocaine), glass microscopic slides, 10 per cent formalin, No. 11 Bard Parker blade, and a rake or applicator stick to remove tissue from the syringe.

To demonstrate the technique of aspiration biopsy, figure 7 depicts a 65 year old white male, presenting a slowly growing painless mass in the right parotid area. Aspiration biopsy is being performed to establish whether this tumor is a pleomorphic adenoma or a cancer, primary or secondary in the parotid area. Preservation of the facial nerve and possible neck dissection will depend on the result of this biopsy. After cleansing the skin, a few drops of lidocaine hydrochloride are injected. The skin is then nicked with a No. 11 blade to facilitate entrance of the No. 18 needle and to prevent a fragment of cutaneous epithelium from being included in the biopsy specimen (fig. 8). Then holding the syringe as



Fig. 11. — Preparation of "smear."

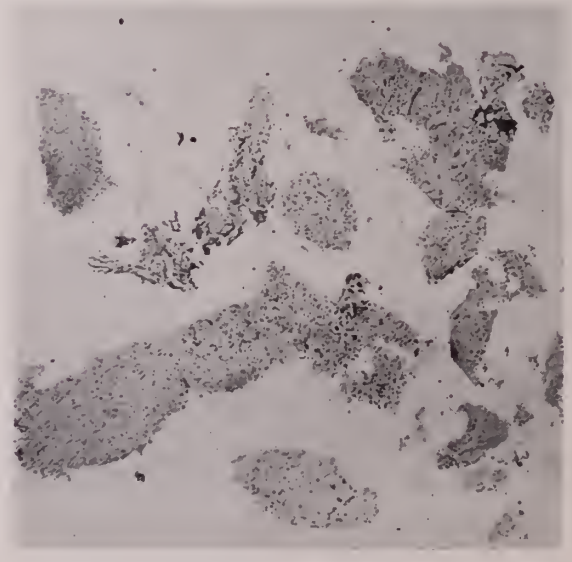


Fig. 12. — Aspiration "clot" (x40). Pleomorphic adenoma of parotid gland.

shown in the photograph and with the other hand fixing the tumor mass, one inserts the 18 gauge disposable needle into the tumor through the previously made skin puncture. With practice one learns to recognize the distinctive, abrupt lessening of resistance as the needle penetrates the tumor capsule.

As the tumor is entered, the plunger is then withdrawn half way or more, maintaining a high vacuum within the syringe (fig. 9). The needle is then advanced back and forth in the tumor, with several short strokes and change of direction of the needle so that the fragments of the tumor entering the needle are severed from their attachments. The needle is withdrawn and the aspirate is collected from the barrel of the syringe and placed on a square of blotting paper (fig. 10). This is designated the "clot" and is placed in 10 per cent formalin. It will be prepared by the pathologist by routine paraffin sections.

The remaining material is placed on a glass slide (fig. 11) and a thin smear is prepared as shown in the photograph. Smears may be placed in 95 per cent alcohol or air dried. They are particularly useful in metastatic squamous cancer and can be read in a few minutes after being stained. Occasionally an extremely vascular tumor will yield mostly blood on aspiration, which clots readily in the syringe. This entire clot can be sent in formalin for sectioning and often the diagnosis can be made from the clumps of tumor cells suspended therein (fig. 12). This is the "clot" aspirated from the parotid tumor and it was read by the pathologist as a pleomorphic adenoma. With this preoperative information, a superficial parotid lobectomy with dissection and preservation of the facial nerve was performed.

Comment

As with most procedures, aspiration biopsy has its limitations. Close cooperation and communication between the pathologist and the surgeon are imperative for consistently accurate diagnosis. The pathologist must be given all pertinent clinical data which may help him in arriving at a diagnosis, including the exact location of the tumor, history of previous cancer and laboratory data of significance. Likewise, the pathologist should be alert to the natural history of cancer in the region under suspicion and must be thoroughly familiar with the cytology of tumor aspirates. Practice in reading aspiration biopsies is readily available for these may be prepared from surgically removed specimens.

Implantation of tumor in the needle tract has been reported rarely and can be completely avoided if the site is excised at the time of definitive surgery. The aspiration site should be planned and marked with this procedure in mind.

It must be stressed that negative results of aspiration do not rule out cancer and frequently repeat aspiration may be necessary. Incisional biopsy is always performed when confirmation of the diagnosis cannot be obtained by the aspiration. Incisional biopsy is the procedure of choice in ulcerated tumors, cancer of the breast, deep inaccessible tumors, and lymphomas in which the pathologist requires the entire node for detailed architectural study.

Summary

The historical background of aspiration biopsy is given, establishing its usefulness as an aid to rapid diagnosis of cancer in accessible tumors.

Applications of aspiration biopsy in various clinical settings are discussed in detail, particularly its role in providing a tissue diagnosis for definitive treatment and thereby diminishing the risk of surgical implantation.

The technique is demonstrated in detail, and its advantages and limitations are outlined.

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The Present Status of Steriod Therapy in Ulcerative Colitis

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The purpose of this paper is to review the current status of steroids in the treatment of idiopathic ulcerative colitis. Although much information has appeared in the literature regarding their relative effectiveness, the best mode of administration and the incidence of complications, most reports have been based on uncontrolled observations, without significantly large populations or statistical analysis. Recently, to evaluate the position of steroids and related compounds in the treatment of ulcerative colitis, several controlled therapeutic trials have been performed providing comparative studies, with randomization of patients and systematic prospective observations.

Evaluation of Steroid Therapy

It is thought that a review of these recent studies may provide meaningful information regarding the effectiveness and limitations of this mode of therapy.

1. Most patients treated with steroids will have a full remission or are improved. Truelove and Witts,[1] through the aegis of the Medical Research Council of England, evaluated steroid therapy in 210 patients from five area hospitals who were randomized into equal groups and treated for six weeks. One group was treated with 100 mg. of cortisone every day and the other group with a dummy preparation. They observed that 69 per cent of the patients in the cortisone-treated group had a full remission or were improved as compared to only 41 per cent of the patients treated with placebo.

2. Cortisone is beneficial in attacks of ulcerative colitis of all grades of severity, both first attacks and in relapse of established disease.[1] In the same study these authors observed that in every stage of severity of the illness and in first attacks and relapses the cortisone-treated patients did better than the corresponding control patient.

3. The patients with milder forms of the disease show a higher percentage of favorable results.[1] Thus, cortisone is worthy of trial in all patients irrespective of the severity of the illness, unless specific contraindications for their use exist.

4. Cortisone and ACTH are equally effective in therapy of the initial episode.[2] In a study involving 169 patients admitted to the hospital during the first episode of ulcerative colitis, a comparison was made between the effect of oral cortisone, 50 mg. four times a day, and intramuscular ACTH gel 80 units per day. Truelove and Witts[2] observed that the clinical response in the patients treated with cortisone or ACTH was essentially equal.

5. In the treatment of patients in relapse, ACTH is more effective than oral steroids. Truelove and Witts[2] found that 70 per cent of the patients had a full remission on ACTH in contrast to 37 per cent of patients treated with cortisone. The superiority of ACTH was observed even in the patients responding to cortisone in their first episode.

6. The optimal dose of oral prednisone is 40 mg. per day which produces fewer side effects than 60 mg. and significantly greater therapeutic benefits than 20 mg. Baron and his associates[3] compared the effectiveness of 20, 40, and 60 mg. of prednisone in the treatment of active ulcerative colitis in 58 patients in an outpatient clinic over a five week period. They found symptomatic improvement more often in patients given 40, or 60 mg. per day than those given 20 mg. per day. The incidence, however, of side effects such as moon-facies, acne, hypertension and edema was higher among patients given 60 mg. per day. Thus, 40 mg. of prednisone is the optimal dose.

7. After a full or partial remission has been achieved, maintenance therapy with reduced doses of steroids does not alter the relapse rate. In the study of Truelove and Witts,[2] the relapse rate during an 18 month observation period was 49 per cent in patients on a maintenance dose of 50 mg. of cortisone per day and 42 per cent in patients treated with placebo.

8. The topical use of steroids by rectal instillation in enema form is effective. Truelove and

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Hambling[4] initially suggested this therapy in the form of hydrocortisone hemisuccinate sodium, 100 mg. dissolved in 100 cc. of saline given as a retention enema twice a day. Two independent double blind control trials were carried out, and showed a marked superiority of local steroids over a dummy preparation.[4,5] In general, however, this treatment has been used for left-sided colitis or the milder forms of the disease and a satisfactory trial has not been made in the more extensive forms of universal ulcerative colitis. Local corticosteroid treatment with a solution of prednisolone 21-phosphate, which is stable and can be prepacked in plastic bags, has likewise been shown to be effective in the controlled therapeutic trial conducted by Matz.[6]

9. In spite of the beneficial effects of ACTH and steroids, their use is not without hazard. A study of 340 cases for as long as 10 years by Spencer and his associates[7] illustrated a striking incidence of complications. A cushingoid appearance was almost universal and in approximately 50 per cent of the patients serious complications such as infection, osteoporosis, hypertension, diabetes, psychosis and hypokalemia, developed.

Summary and Conclusions

The present status of steroid therapy in the treatment of ulcerative colitis has been reviewed in the light of recent controlled clinical trials. At present, the following can be stated regarding effectiveness and limitations of steroid therapy.

1. Steroids will effect a full remission or improve most patients with ulcerative colitis.

2. Steroids are beneficial in the treatment of first attacks and in patients in relapse.

3. Steroids are more effective in the milder forms of the disease.

4. Cortisone and ACTH are equally effective in the treatment of the initial episode.

5. ACTH is more effective than steroids in the treatment of patients in relapse regardless of the initial form of therapy.

6. The optimal dose of steroids is prednisone 40 mg. per day or equivalent doses.

7. Maintenance therapy with steroids does not alter the relapse rate.

8. Topical use of steroids is effective.

9. In approximately 50 per cent of patients on maintenance steroid therapy serious complications will develop.

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University of Florida.

Data Needed for FMA Archives

Under the able leadership of Dr. Clifford C. Snyder, the Archives Committee of the Florida Medical Association inaugurated a program to obtain adequate biographical data on each of the members. The Association, from time to time, receives requests for such data and is often embarrassed to be unable to supply them. Archives Data Forms were mailed to the members according to age decades: those over 60 years, mailed in 1960; those 50 to 60, mailed in 1961; and those 40 to 50, mailed in 1962. The percentage of members not returning these forms up to the present date is by age groups: 44%, 46%, and 65% respectively. We will again mail forms to the delinquent members. Please, if you are among this group, give this form your prompt attention, complete it and return it without delay.

William M. Straight, M.D., Chairman
Committee on Archives

Improper Use of the Walking Heel

With Case Presentation

T. Hartley Davis, M.D.
OCALA

The purpose of this paper is to point out the possible damage which can occur in the treatment of ankle fracture following the use of the walking heel incorporated in the cast, and to illustrate the unfortunate selection of cases in which this form of apparatus is not only not useful but is specifically contraindicated. In case of a fracture of the shaft of the fibula or of the tibia in which impaction of the fragments is desired, the walking heel might be useful provided one uses a tight cast to prevent the possibility of angulation of the shaft alignment. A walking heel should never be used on a cast when the shafts of both the tibia and fibula are fractured at the same level. In some cases of single malleolus fracture in which the ankle joint is stable and impaction of the fragments is desired, the walking heel might also be useful.

Certainly, in the treatment of fractures of the tarsal bones, particularly the os calcis and the astragulus, the walking heel will tend to worsen the position of the fragments. In fractures of the metatarsal bones, the use of the walking heel could cause an upward bowing of the shafts of these bones and cause angulation of the fracture sites if they were in the shaft. In the case of multiple malleolus fractures, either bimalleolar or trimalleolar fractures, an unstable ankle joint is always produced. If, in the treatment of these fractures, after perfect reduction, pressure is added from below, as a patient's weight upon a walking heel, the reduction will collapse and the ankle mortise will be badly distorted.

Report of Case

A white woman, 84 years of age, weighing 180 pounds, fell and fractured the left ankle (trimalleolar fracture). The fragments were all in good position after application of a cast to the knee. A walking heel was installed on the cast in good position. Reduction of all three fractures was excellent.

Two months later the patient was in so much pain that, while in another city, she went to an orthopedist who had x-rays made with the cast still on as shown in the accompanying illustration. It will be seen that the astragulus has pushed its external superior corner upward between the fragments of the fibula and separated them widely. In so doing, the astragulus shifted laterally about 2 cm. and pulled with it the internal malleolus of the tibia a like distance, completely removing it from its position of reduction. Also, the upper surface of the astragulus has rubbed against the lower (joint) surface of the tibia and practically all of the joint cartilage from these two areas is gone. This loss of cartilage produces a most painful situation in the ankle joint. The patient now has such a painful ankle joint that she cannot bear any weight on this foot.

Comment

It is obvious that this patient had a perfect reduction and, had she not walked on the cast, she could have had perfect results. Many persons, including some orthopedists, believe that the pressure in a walking cast is transmitted to the head of the fibula and to the medial tibial plateau. I have proved that this concept is incorrect by a simple experiment which shows that most of the weight is borne by the heel.

A tight plaster cast was built around the foot and leg of a 127 pound subject, after I had previously placed under her heel and midfoot the bladder of a sphygmomanometer with the two tubes extending out through the lateral wall of the cast.



Figure 1.

One of these tubes was connected to a pressure bulb and the other to the mercury manometer to measure the variations in pressure, if any, as the subject's posture varied from standing to walking to sitting. The same experiment was then repeated with the rubber bladder inside the subject's shoe under her heel and midfoot in the same position as in the cast to compare pressures.

Pressure variations in cast:
Standing with weight equally divided on both feet:
Pressure of 200 mm. Hg advanced to 160 mm. Hg (cast)
Standing with all weight on left foot (cast):
Pressure of 20 mm. Hg advanced to 260 mm. Hg
Pressure variations while walking (foot in cast):
Weight off foot in cast—10 mm. Hg
Weight on foot in cast—140 to 160 mm. Hg
Weight off foot in cast—10 mm. Hg
Weight on foot in cast—140 to 200 mm. Hg
Weight off foot in cast—10 mm. Hg
Weight on foot in cast—140 to 210 mm. Hg
Pressure in shoe:
Weight on both feet equally divided
Pressure of 20 mm. Hg
advanced to 130 mm. Hg
Standing with all weight on one foot
Pressure of 20 mm. Hg
advanced to 200 mm. Hg
Walking in shoes:
Step on foot—30 mm. Hg. advanced to 240 mm. Hg
Step on foot—30 mm. Hg advanced to 250 mm. Hg
Step on foot—30 mm. Hg advanced to 255 mm. Hg
Step on foot—30 mm. Hg advanced to 245 mm. Hg

It is to be noted that these pressures were measured not by a spring device but by the weight of a column of mercury.

Summary

It is shown by a simple experiment and by a case report that the walking heel transmits pressure directly to the bottom of the foot, mainly to the heel and not to the head of the fibula nor to the medial tibial plateau as some incorrectly have thought.

This experiment was not original with me. It was suggested to me by Dr. Carlo Scuderi of Chicago.

123 South Magnolia Street.

Narcotic Notice to All Physicians

Please be advised that the classification of dihydrohydroxycodeinone (oxycodone) was changed as of July 3, 1964, from "Class B" to "Class A"; therefore it will no longer be permissible for pharmacists to accept prescriptions for this drug over the telephone. There are many preparations containing oxycodone. Some of the better known are Percodan, Percodan-Demi, Percobarb, Percobarb-Demi, and Nucodan. The authority for this statement is the Registrants Mimeograph No. 154 from the Treasury Department, Bureau of Narcotics, Washington 25, D. C., which is quoted in part below:

"*Signed, Written Prescription Required*—Effective July 3, 1964, preparations containing oxycodone may be dispensed by pharmacists pursuant to a physician's *signed and written prescription only,* irrespective of when the product was produced or purchased. Until July 3, 1964, these preparations may be dispensed by pharmacists on oral or written prescriptions and from packages labeled either as "Class A" or "Class B."

May we also call to your attention that it is illegal for your *employees* (nurses, technicians, secretaries, etc.) to telephone prescriptions for *anything* to pharmacists; i.e. narcotics, barbiturates, amphetamines, or so-called "legend drugs." To do so is a violation of the Medical Practice Act, Chapter 458 FSA; Pharmacy Law, Chapter 465 FSA; Narcotic Drug Law, Chapter 398 FSA; Barbiturate Law, Chapter 404 FSA. To allow such practice places you in the position of a conspirator and liables you equally under the law. Infractions of the law will be reported to the Florida State Board of Medical Examiners for possible disciplinary action.

Please govern yourselves accordingly.

s/ Frank S. Castor, Director
Florida State Board of Health
Bureau of Narcotics, and
Homer L. Pearson, M.D., Director

Clinicopathological Conference

University of Florida College of Medicine

D. R. Shanklin, M.D., Assistant Professor of Pathology and Pediatrics.
George T. Harrell, M.D., Dean and Professor of Medicine.

A 42 year old white married housewife was admitted to the University of Florida Teaching Hospital 13 days prior to death with the chief complaint of weakness.

Present Illness.—She was first seen in the General Clinic three weeks before admission with the same complaint. She had been in relatively good health until May 1959, six months prior to admission. At that time vague pain developed in the right flank similar to that she had previously experienced with pyelonephritis. Her family physician thought this symptom was related to family stress and treated her for "nerves" with an unknown medication. Five months prior to admission she noted the gradual onset of generalized weakness and diffuse, nocturnal soreness, without cramps, in the proximal muscles of both lower extremities. Her legs sometimes felt numb and her feet became cold in association with the numbness. There was no apparent relation of this difficulty to exertion or to position. Partial relief was obtained by placing a pillow under her knees and/or by leg massage. This symptom gradually progressed to become a regular nocturnal event and by three months prior to admission assumed a diurnal pattern as well.

Extensive dental caries were noted and extractions were planned on the possibility that her symptoms might be related. Two months prior to admission her difficulties were supplemented by anorexia and frequent nausea without vomiting, and she confined her diet almost entirely to soup and bread. About this time she also began to experience occasional dysphagia with both solid and liquid food which seemed to stick behind the breastbone. In addition, there appeared to be perioral tightness with difficulty in fully opening her mouth. Episodic, transient bouts of ill-defined, diffuse, epigastric distress and fullness, unrelated to food or time, and unassociated with eructations or flatus, began to occur. By one month prior to admission her weight had fallen from her normal 165 pounds, which she had weighed in June, to 138 pounds. The dental extractions were deferred by her dentist because of her "physical condition."

At this time her family physician found her "severe weakness incompatible with the physical examination and the laboratory findings." He did, however, note a hemoglobin level of 10 Gm. per hundred milliliters and started the patient on biweekly injections of "liver" extract as well as multivitamin capsules. She reported some initial subjective improvement following this treatment, but subsequently she continued to feel progressively weaker with pronounced weakness and soreness in the thighs and on this account virtually confined herself to bed. During this period nocturnal sweating and fever with transient bouts of delirium manifested by incoherent speech and uncoordinated ocular movements appeared. Such episodes lasted one to two hours, with subsequent amnesia for the event. No temperature record was kept. Throughout this period she became depressed with frequent crying spells and insomnia, as well as temper outbursts without overt provocation.

Past History.—She had viral pneumonia and concomitant pyelonephritis in 1955 and recurrent pyelonephritis in 1956. These were described as having typical symptoms and there was a good response to treatment with medications of unknown type without sequelae.

Family History.—Family adversities and related anxiety on the part of the patient were acknowledged in the period of four years that the patient had lived in Florida. No history of previous emotional instability in the patient or her family could be elicited.

Review of systems.—The patient denied enlargement of the neck and gave no history of heat or cold intolerance, palpitation, tremor or recent menstrual changes. There was an equivocal history of hoarseness and since taking to bed she had noted two three day bouts of constipation with black stools. Skin, hair and speech changes were denied. There was no specific history of barbiturate use and urine color changes were denied. She gave no history of exposure to tuberculosis, toxins or ingestion of raw meat.

Physical Examination in the Clinic.—The pulse rate was 92, respirations 20 and blood pressure 100/80 mm. Hg. She was 5 feet 3 inches tall and weighed 138 pounds. She was a well developed, well nourished alert and cooperative white woman who appeared somewhat obese and chronically ill with a generalized pallor and a round puffy face. Her feet were cold, but skin temperature was otherwise normal and there were no noted abnormalities on the skin or in the hair texture although the eyebrow hair was sparse. Funduscopic examination revealed multiple discrete, yellow-white opacities bilaterally, most of which were in a perivascular distribution. The teeth were grossly carious and there was obvious limitation in the opening of the mouth. The voice was deep. There was a grade 1, soft, blowing precordial systolic murmur. Examination of the heart and lungs was otherwise within normal limits as was examination of the abdomen. A thick, purulent discharge was noted about the cervix. Reflexes were symmetrically decreased without delay, and she was unable to raise either leg more than 15 inches above the examining table when supine. Upon attempting to do so the examiner could detect a downward pressure in the contralateral leg by placing his palm under the heel of the contralateral leg.

Accessory Clinical Findings in the Clinic.—Examination of the blood revealed a hemoglobin level of 11.4 Gm. per hundred milliliters and a white cell count of 7,850 with a normal differential. Urinalysis revealed a pH of 6.5, a specific gravity of 1.020, 3 plus proteinuria, a negative sugar and acetone, and multiple bacteria on microscopic examination. The serological tests for syphilis gave negative results. Cervical smear and culture yielded Staphylococcus albus and diphtheroids. An upper gastrointestinal series and pelvic films were normal. Films of the lumbar spine revealed a slight narrowing between the fourth and fifth vertebrae. No other lesions were detected. The spleen appeared enlarged on the x-rays.

Course in the Clinic.—An initial impression of psychoneurosis was entertained and the patient was given prochlorperazine and multivitamins, and was encouraged to increase her dietary intake. Follow-up appointments were made. Upon her return one week later the symptoms were unchanged and a diagnosis of hypothyroidism was considered. At this time blood was drawn for a protein-bound iodine test and thyroid extract, 60 mg. per day, was started. A third visit one week later revealed continued progression of the symptoms and at this time she had lost an additional 5 pounds. She seemed disproportionately happy and unconcerned in the light of the symptoms and both she and her husband were at this time inclined to attribute them to "nerves."

Further laboratory and x-ray studies were obtained and she was asked to return in 10 days. Studies reported in the interim showed a hemoglobin level of 11.8 Gm. per hundred milliliters, a hematocrit reading of 41 per cent, a white cell differential of 8 per cent lymphocytes, 90 per cent segmented neutrophils and 2 per cent band forms. Urinalysis showed a 1 plus proteinuria and the microscopic examination of the urine revealed multiple bacteria and two to four white blood cells per high power field with occasional granular casts. The protein-bound iodine was reported as 4 micrograms per hundred milliliters. Skull films were within normal limits. Chest films suggested a slight biventricular enlargement with a minimal increase in pulmonary artery shadows. There was an unusual degree of shoulder girdle elevation and a slight scoliosis. An electrocardiogram taken at the final clinic visit revealed a sinus tachycardia with a marked rightward QRS shift and a T-vector directed to the left and anteriorly indicating right ventricular hypertrophy and ischemia.

Course in the Hospital.—At the time of admission the patient was too weak to raise her arms over her head and could not lift her head off the bed. She was unable to turn over in bed without assistance. Periorbital edema had been present for about a week and transient postural syncope was noted three days before. She had severe bilateral knee pain without redness, swelling or heat. This was accentuated by exercise and relieved by meprobamate. Physical examination revealed a blood pressure of 100/80 mm. Hg, a pulse rate of 150 per minute which was regular, and a respiratory rate of 18. The temperature was

37 C. (98.6 F.). Examination was much as noted in the clinic with the exception of periorbital edema and marked tachycardia with an accentuated pulmonic second sound. There was minimal left-sided cardiac enlargement and the spleen was felt 2 fingerbreadths below the costal margin. There was muscle tenderness over the proximal muscles of all extremities with mild atrophy and contracture and mild weaknesses were noted.

Laboratory findings revealed a hematocrit level of 42 per cent, a white blood cell count of 8,000 with a differential count of 72 per cent segmented neutrophils, 1 per cent eosinophils, 24 per cent lymphocytes and 3 per cent monocytes. By the day preceding death the white cell count had risen to 18,000 with a similar differential count. The platelets were normal on both occasions. Urinalysis on admission revealed a 1 plus proteinuria, a 3 plus acetone and no sugar. The microscopic examination of the urine revealed 10 to 15 red blood cells per high power field and five to seven white blood cells per high power field. The specimen was thought to have been con'aminated by menstrual flow and a repeat urinalysis on the eighth hospital day revealed a 2 plus proteinuria without other remarkable findings. The urine was tested for 5-hydroxyindole acetic acid and was found to be negative. Two stool specimens were guaiac negative. The serological tests for syphilis gave negative results. The blood sugar was 79 mg. and the blood urea nitrogen 10 mg. per hundred milliliters. The total protein was 6.6 Gm. per hundred milliliters and the albumin 2.3 Gm. The transaminase was reported as 86 units and LE preparation was negative.

Chest films showed the heart to be within upper limits of normal size with no changes since the films taken during clinic visits. After two weeks of hospitalization, however, cardiac enlargement was noted and a right-sided pleural effusion was found. A film of the abdomen and barium enema were normal. An upper gastrointestinal series revealed a normal esophagus. In the stomach there was some herniation of the mucosa through the pylorus which suggested antral gastritis. There also appeared to be a widening of the duodenal shadow with a mass in the region of the head of the pancreas. An electrocardiogram on admission revealed no change. Shortly after admission a biopsy was made.

Therapeutic measures included meprobamate, phenobarbital, and prednisone 60 mg. daily, given in conjunction with aluminum hydroxide gel. A physical therapy program was begun. The patient remained afebrile throughout hospitalization, but continued to become progressively weaker. Shortly after admission the pulse rate returned to normal, but thereafter she experienced frequent episodes of paroxysmal tachycardia. Four days prior to death a right ventricular gallop was noted and the patient was digitalized. Three days prior to death she complained of diffuse abdominal tightness and pain associated with sweating, several loose stools and nausea. These symptoms were not altered by Pro-Banthine and two days prior to death enlargement of the liver was noted. The presence of ascites could not be definitely determined. The day preceding death her condition remained unchanged, and dyspnea, progressing over a two hour period with irregular gasping respirations, occurred and was not relieved by artificial respiration, the use of airway oxygen and intracardiac adrenalin.

Dr. George T. Harrell (Dean and Professor of Medicine):

This is the story of the fatal illness, of six months total duration, in a 42 year old white, married female Florida resident. The family history has revealed no emotional instability and otherwise is of no help. In the past, the patient's general health had been good. In 1955 she had an attack of viral pneumonia with pyelonephritis and the following year, recurrent pyelonephritis, treated with "pills," most likely a sulfonamide. It was at this time she moved to Florida.

The present illness began in May 1959 with an attack of pain in the right flank, similar to that associated with her previous attacks of pyelonephritis. We do not know if she had fever or urinary symptoms at this time. In any event, by June she noticed generalized weakness, and muscle soreness without cramps, first occurring at night in the thighs, but by August it was present day and night. By September she had difficulty opening her mouth and by October was confined to bed. No relation to exertion or position is noted. Subjectively, she had numbness and coldness. Pains in the knees developed. By September, she had anorexia and nausea without vomiting. Dysphagia developed and food seemed to stick behind the sternum. She had two three day periods of constipation with black feces. There was diffuse epigastric distress and fullness, all pointing to gastrointestinal dysfunction. By October, her weight had dropped from the usual 165 to 138 pounds, with a further loss to 133 pounds

by November. She had nocturnal sweating and fever. Delirium with abnormal ocular movements in bouts of one to two hours associated with crying, temper outbursts, insomnia and depression developed. These symptoms suggest a progressively fatal, uninterrupted disease process.

On physical examination she was afebrile. The pulse rate first noted at 92 increased to 150 with episodes of paroxysmal tachycardia. The respirations are noted at 20 and blood pressure at 100/80 mm. Hg. She appeared chronically ill, obese and pale, with a puffy face and periorbital edema. Muscle tenderness was noted proximally in the arms and legs with mild atrophy of the musculature. Contractures had developed and because of the weakness she could not raise her head, turn over, or raise her legs, even though she was trying, and could not raise her arms over her head. Her feet were cold, though the skin temperature appeared to be essentially normal and no eruption was noted; no comment is made on abnormal pigmentation. Her voice was deep, and the eyebrows were sparse but the hair texture was said to be normal. Incidental findings were carious teeth and a cervical discharge. An important finding was the discrete yellow-white perivascular retinal opacities. The soft systolic murmur over the precordium and postural syncope indicate involvement of the vascular system. The accentuated second pulmonic sound, tachycardia, and gallop rhythm point to cardiac involvement. Signs of pleural effusion are noted, but no signs of ascites are described. With these signs, the dyspnea, and the enlargement of the liver extending 2 fingerbreadths below the costal margin, it is apparent that the myocardium was failing. The spleen was enlarged probably because of congestion.

Accessory clinical findings showed a hemoglobin level of 10 Gm. in October, increasing to 11.8 Gm., though the hematocrit reading remained in the range of 41 per cent. The white blood cell count increased from 7,850 to 18,000 with the differential count showing an increase in polymorphonuclear cells from 72 to 92 per cent and a concomitant drop in the lymphocytes which varied between 8 and 24 per cent. The monocytes ranged from 0 to 4 and eosinophils from 0 to 1 per cent. Platelets are always described as normal in number. The urine specific gravity of 1.020 would not indicate any great diminution in renal function in spite of the persistent proteinuria varying from 1 to 3 plus. No sugar is recorded, though the increase in acetone from 0 to 3 plus is consistent with the decrease in food intake and resulting acidosis. The presence of white blood cells and bacteria in an uncatheterized specimen is not too unusual. The presence of occasional granular casts would suggest renal involvement or severe dehydration. If the presence of red blood cells in the urine was confirmed on a catheterized specimen, it would be of great significance. The negative guaiac tests on the stools would indicate no ulceration in the gastrointestinal tract in spite of the history of black feces. The negative serologic tests for syphilis might be anticipated. The negative preparation for the presence of lupus erythematosis cells is of considerable significance. The cultures from the cervix of staphylococci and diphtheroids are of little significance.

The electrocardiogram on November 3 showing right ventricular hypertrophy and ischemia with sinus tachycardia is significant and would indicate some interference with blood flow through the pulmonary circuit. The blood chemical findings of sugar 79 mg. and blood urea nitrogen 10 mg. per hundred milliliters, transaminase 86 units and protein-bound iodine 4 micrograms per hundred milliliters are not remarkable. The total protein of 6.6 Gm. per hundred milliliters is low and the reversal of the albumin-globulin ratio with values of 2.3 and 4.3 Gm. respectively indicates a chronic process. The radiological examinations showed progression of enlargement of the heart; the minimal accentuation of pulmonic arteries is consistent with the electrocardiographic findings. The finding of a questionable mass in the epigastrium, near the head of the pancreas, may be of considerable significance. Other radiologic examinations of the gastrointestinal tract show no lesions in the esophagus in spite of the history of food appearing to stick behind the sternum. These substernal symptoms could hardly be explained by the herniation of the mucosa of the stomach through the pylorus. The negative barium enema also is consistent with the absence of prolonged lower bowel symptoms. X-rays of the skeletal system showed no lesions in the skull, scoliosis, a high shoulder girdle, and narrowing between the fourth and fifth lumbar vertebrae; each of these findings may be found in a number of processes. It is unfortunate that no intravenous pyelograms are recorded.

The disease process followed a progressive downhill course, with weakness, diffuse abdominal

pain, loose stools and nausea, ending in respiratory failure.

The therapeutic trial on thyroid extract of 60 mg. per day appears to have induced no change in the approximately one week it was used. The use of liver and vitamins was simply supportive. The treatment of psychological symptoms with tranquilizers gives no hint as to the underlying disease process. Apparently, the administration of prednisone and the dosage used did not alter the course.

In differential diagnosis, one must consider pyelonephritis. The absence of an elevated blood pressure, the high specific gravity of the urine and the presence only of granular casts do not confirm such an impression. Edema is not a common finding in chronic pyelonephritis. Of possible disturbances of thyroid function, thyrotoxicosis might be suggested by the increase in pulse, paroxysmal tachycardia, loss in weight and late development of loose stools. On the other hand, the absence of enlargement of the thyroid gland and of the eye signs of protrusion or lid lag would be against this diagnosis. Myxedema might be suggested by the low voice, sparse eyebrows, mental disturbances and presence of periorbital edema, but the rapid pulse and the failure of dramatic response to an adequate dose of thyroid would rule this possibility out.

An infection is suggested by the history of pyelonephritis, and the presence of staphylococci in the cultures of the cervix, but the symptoms are generalized. The enlargement of the liver and spleen and the presence of proteinuria raise the rare possibility of leptospirosis. The periorbital edema and the muscle soreness are suggestive of trichinosis, but the duration of the disease, steady progression of the symptoms and the absence of eosinophilia would be against this diagnosis.

A steady downhill progression would suggest the possibility of malignant disease. The presence of red blood cells in the uncatheterized urine would make one think of the kidney, but no enlargement was noted on physical or radiological examination. If pyelograms had been made, this possibility could be ruled out more easily. In the pelvis, the ovary is a possible site for cancer, but no abnormal physical findings on pelvic examination are described. Another possibility is the body of the pancreas, but physical findings are difficult to obtain with a malignant condition in this site. Malignant disease of the pancreas often is associated with psychic phenomena. If there is a malignant lesion, metastases would be expected in the peritoneum, pleura and intracerebrally to account for some of the psychic symptoms.

Of generalized metabolic disturbances, porphyria must be considered. Often, this process can be detected by the simple process of exposing the urine to sunlight to observe a color change. The presence of cerebral symptoms and muscle weakness is compatible, as are some of the gastrointestinal symptoms. A collagen disease, such as scleroderma, is suggested by the difficulty in opening the mouth and the symptoms suggesting involvement of the esophagus. The absence of radiographic confirmation of esophageal thickening would be against this diagnosis, as would the absence of thickening in the skin. The laboratory test withheld very likely is a biopsy of skin and muscle. Lupus erythematosis would be suggested by the occasional fever and the reversal of the albumin-globulin ratio, but the absence of typical skin findings and the negative preparation for the presence of lupus erythematosis cells in the circulating blood would be against this possibility. The most likely diagnosis, therefore, is dermatomyositis, based on the muscle tenderness, weakness, periorbital edema and the findings in the arterioles of the retina. It is of interest that in a number of cases of dermatomyositis with a progressive course malignant disease has been found at autopsy. Though the symptoms could all be explained on dermatomyositis alone, the possibility of the simultaneous presence of a carcinoma of the pancreas should be considered as a rare precipitating factor.

Clinical Diagnoses

Collagen disorder, probably dermatomyositis
Pyelonephritis, chronic
Hypothyroidism

Dr. Harrell's Diagnoses

Collagen disorder, probably dermatomyositis
Internal malignancy, possibly carcinoma of the pancreas

Dr. D. R. Shanklin (Assistant Professor of Pathology and Pediatrics):

Autopsy revealed a chronically ill white female approximately 40 years of age with (1) pale skin which felt tight and slightly thickened; (2) an increased amount of hair on the face; (3) a mild cushingoid facies; (4) a protuberant abdomen; (5) a well healed 5 cm. incision over the left anterior thigh; (6) 2 plus pitting edema of the legs; and (7) a dull percussive note over the ab-

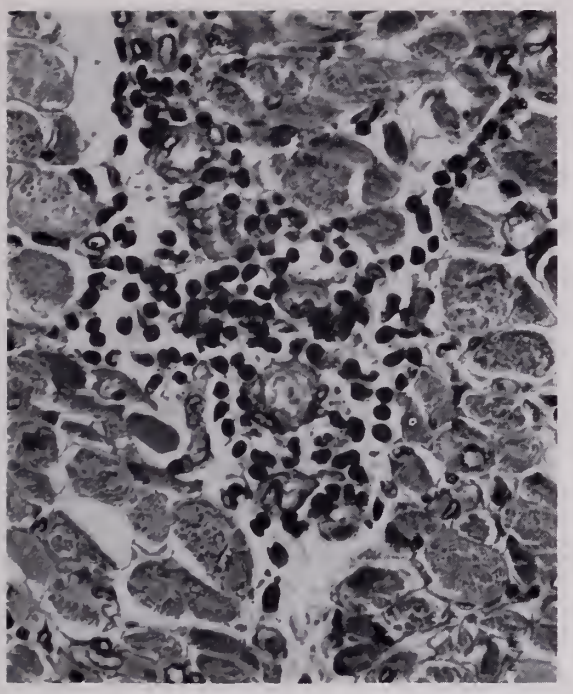


Fig. 1. — Biopsy of muscle showing nodular perivascular lymphocytic infiltration seen infrequently in muscle taken at autopsy. Hematoxylin and eosin. 575 X.

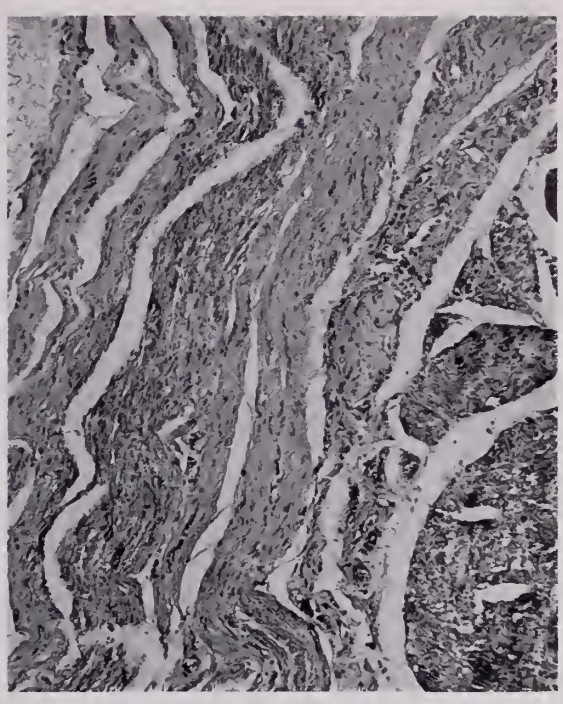


Fig. 2. — Wall of esophagus showing loss of muscle with collagenous replacement. Hematoxylin and eosin. 110 X.

domen and thorax. On incision, the anterior musculature was well developed and presented a normal beefy red, slightly moist appearance. The abdominal panniculus was 3 cm. thick. The serosal surfaces were smooth and glistening with a few readily broken adhesions which were present over the superior surface of the liver and which descended 7 cm. into the abdomen beyond the costal margin. There was 1,000 cc. of straw-colored fluid in the abdominal cavity; 750 cc. in the right pleural cavity; 400 cc. in the left pleural cavity; and 200 cc. in the pericardial cavity.

Numerous fine and easily broken adhesions were present over the lower lobes of both lungs. The lungs weighed 600 Gm., were slightly moist and showed alternate areas of collapse and emphysema. The parenchyma cut with moderately increased resistance. On the cut surface the pulmonary arteries stood out sharply and did not collapse. They were variably yellow in color. The spleen weighed 275 Gm., showed a smooth capsular surface and was firm with a normal cut surface. It cut with resistance. The liver weighed 1,500 Gm., was soft, yellowish to whitish grey and on section showed a marked accentuation of the centrilobular pattern. Blood flowed moderately from the section surface. The heart weighed 400 Gm. and was generally dilated. The left ventricle was 1.0 cm. thick except at the apex where it was 0.7 cm. The right ventricle was especially dilated particularly in the outflow tract and measured 0.6 cm. The pulmonic valve circumference was 6.5 against the aortic of 5.5 cm. The musculature was a diffuse, irregular pale dirty yellow-red, most marked in the apical septal area of the left ventricle in a zone measuring 5 by 6 cm. Here some endocardial thrombotic material was seen. The yellowing was prominent in all parts of the right ventricle. The kidneys were grossly normal No masses were found in the pancreas.

The biopsy that was performed during hospitalization showed: (1) atrophic skin (epidermis) and increased collagen in the dermis; and (2) mild focal collections of chronic inflammatory cells in the muscle with some mild degenerative change in the fibers. This was interpreted as compatible with dermatomyositis (fig. 1). It should be remembered at this junction that there is a spectrum of histologic change between scleroderma and dermatomyositis. There are many confusing points between dermatomyositis and two others of the so-called collagen diseases, scleroderma and lupus erythematosis. In this case the biopsy provided a clue in one direction, but the autopsy shows the result of considering a solitary biopsy in a generalized disease which is known to have many variations.

In terms of therapy this point is minor since the therapies are similar for dermatomyositis and scleroderma. In this case muscular symptoms seemed to predominate. The absence of ring binding in the tissue, however, seems to rule strongly against dermatomyositis as a specific entity in this case. The autopsy tissues show that the skin biopsy is a minimal change compared to other areas of the body while the muscle biopsy is perhaps the most extreme change found in muscle throughout the body. There is very little muscle change elsewhere and it shows the nodular focal polymyositis more characteristic of scleroderma than dermatomyositis (fig. 1). In addition, there are visceral lesions that are more generally associated with scleroderma than with dermatomyositis among which are chronic pericarditis with fibrosis and progressive sclerosis of the esophagus (fig. 2). Both of these are typical lesions in this case. The other skin from autopsy shows liquefaction degeneration of the upper dermis and considerable collagenosis with hyalinization of the deeper dermis with fragmentation of fibers and some perivascular infiltrate. On the basis of these findings together with the minimal muscle disease a diagnosis of scleroderma, or better, progressive systemic sclerosis, would seem warranted.

Because of some similarities with lupus erythematosis, namely a fibrinoid change in the choroid plexus, the kidney was studied with the PAS stain and the glomeruli are essentially normal (fig. 3). The afferent arterioles show a fibrinoid sclerosis and obliteration that have been described, however, in collagen diseases. There is no evidence here for pyelonephritis as was pointed out by Dr. Harrell in his clinical discussion. In the lung there was emphysema with some thickening of the septa, moderate to marked vascular sclerosis and arteriolar thickening and some muscular artery hypertrophy. These are consistent with a mild degree of so-called scleroderma lung disease and have produced a cor pulmonale which is striking. The right heart muscle has a yellowish cast. The cor pulmonale has resulted in a liver with much bile pigment retention due to marked centrilobuler destruction. The spleen was mildly congested, but fibrosis was even more striking and a mild degree of perivascular hyaline cuffing which suggests the diagnosis of lupus. Thus we see another manifestation of the collagen disorder. The effects of therapy must be considered in this case and the adrenal reflects the dose level and duration of steroids with a moderate atrophy and lipid depletion. In addition, the rapidity of the response of the pituitary to such therapy in anatomic terms is illustrated by the basophilic conversion or hyperplasia that is characteristic of Cushing syndrome whether endogenous or iatrogenic.

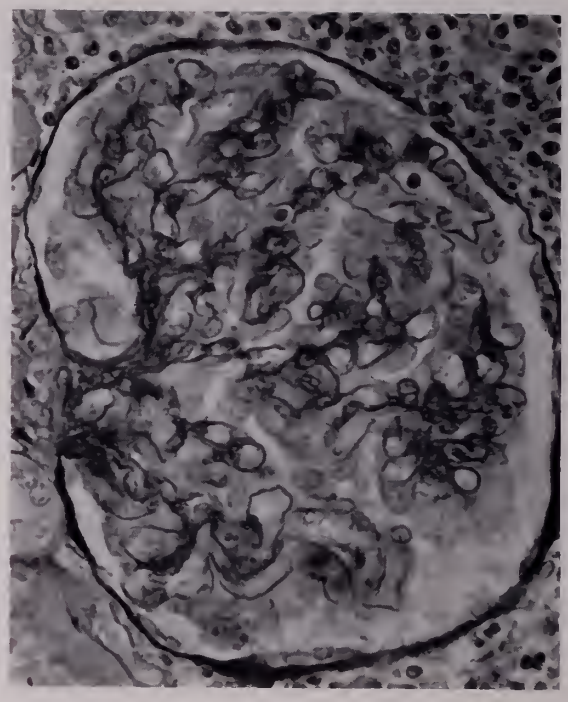


Fig. 3. — Normal glomerulus representative of both kidneys. Periodic acid-Schiff. 575 X.

We thus have a treated case of a so-called collagen disorder which clinically manifested as an acute dermatomyositis which pathologically is more typical of scleroderma, but how did the patient die? The overwhelming majority of patients with dermatomyositis have significant difficulty with deglutition and bronchopneumonia readily develops. This patient does not have pneumonia. The effects of cor pulmonale are striking and by themselves could be fatal. On the other hand, a more striking and unusual lesion is present. After fixation of the heart the yellowish discoloration was even more marked. A mild zone of tissue loss near the apex, not to be confused with the normal degree of taper in this area, with some overlying thrombotic material grossly, could be interpreted as an infarction of eight to 10 days of age, but there is a powerful reason in this case for this not being an apical infarction. Apical septal infarct is not seen in hearts bearing a conus artery. This has been described as occurring in 50 per cent of Negroes and 15 per cent of white patients. A significant conus artery is present in this case. It is approximately one-quar-

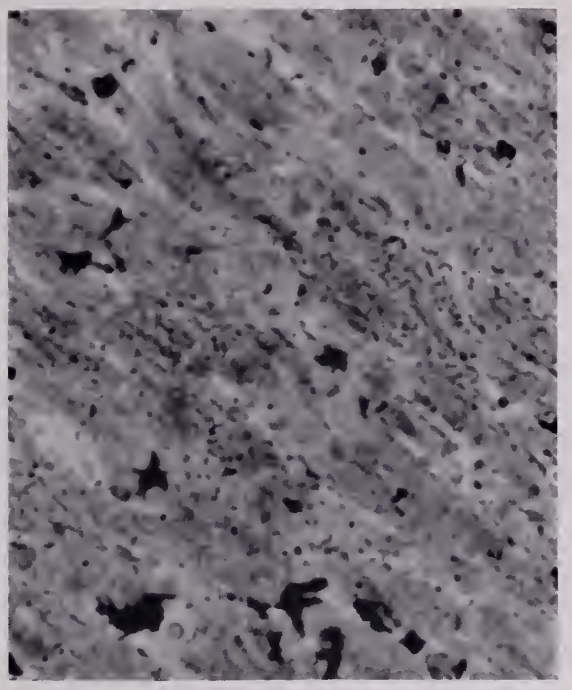


Fig. 4. — Frozen section of heart muscle showing extensive fatty droplet deposition in fibers. Oil Red O. 575 X.

ter to one-third the size of the right coronary artery and is therefore a major and important vessel arising directly off the aorta. Apicoseptal infarction of the heart has not been described in cases with a conus artery unless that artery itself is occluded which in this case it is not. The mural thrombus is an antemortem one and shows a modest marginal organization indicating that the underlying process responsible for it has existed for a week to 10 days. This would indicate a progressive failure which, due to the hypertrophy of the right myocardium, would further compound that situation and promote additional right heart failure. The support of this view is indicated by the effusions and the necrotic changes in the liver.

The crux of the matter is the change beneath the endocardium, and careful histologic examination shows not a typical infarction of eight or 10 days of age but rather a peculiar vacuolated appearance of otherwise normal fibers. This change is diffuse throughout the heart and on re-examination the heart grossly presents a typical tigroid dirty yellow appearance that is diagnostic of massive fatty degeneration of the myocardium. The fat is massively deposited and is within the fibers. Fat stain shows this relationship very well (fig. 4). Fatty degeneration is best considered a resultant lesion and is often seen in marked anemia (this patient had anemic levels on several occasions to complicate the cor pulmonale) but in this massive a degree can be considered as a direct mechanical injury to the heart action with failure and death.

In summary, the anatomic findings in this fascinating case show an overlap between the textbook descriptions of dermatomyositis and scleroderma with a preponderance of findings more typical of the latter and an atypical type of fatal heart disease.

Anatomical Diagnoses

Progressive systemic sclerosis ("scleroderma") involving skin, muscle, esophagus, spleen, lung and pericardium. Nodular polymyositis

Emphysema, lung

Cor pulmonale

Fatty degeneration, myocardium, severe, with cardiac dilation

Centrilobular atrophy, liver, with bile retention

Hyperadrenocorticism, iatrogenic, with pituitary basophilism; atrophy, adrenal cortex

Vascular anomaly, accessory coronary artery, conus type

Endocardial thrombosis, left ventricle, apex, with early organization

(Anemia) Erythropoietic hyperplasia, marrow

Ascites (1,000 cc.), pericardial effusion (200 cc.), and pleural effusion (750 cc., right, and 400 cc. left)

Cutaneous biopsy site, healed, left thigh.

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President's Page

Our AMA

Since its founding in 1847 physicians have directed the affairs of the American Medical Association in serving as the voice of medicine in our country. With the cooperation of state and local medical societies and individual physicians, our AMA has done a good job. Because we, as individuals, are busier than ever with our own affairs as well as with innumerable ancillary activities, it has been necessary for our AMA to depend more and more on employed personnel to conduct many of its affairs. Fortunately a few dedicated, able physicians like F. J. L. Blasingame and Ernest B. Howard are still willing to provide the necessary direction for our employees.

Through a Board of Trustees and a House of Delegates we doctors maintain our control of this vast organization. Those of us who have attended AMA meetings have seen representative democracy in action. Any member has a voice at reference committee hearings. A few "crackpots" muddy our water and a few bureaucrats attempt selfish direction, but on the whole the majority voice of us local doctors decides the issues.

Be this not the case, delegates from the state associations may be changed by a vote of their membership, and members of the Board of Trustees, who can serve only two terms, may not be reelected for their second tenure. Lest we forget, so long as we exercise these rights, our AMA will not become an autocratic bureaucracy; if we fail to exercise them, we probably deserve that fate.

We in Florida are fortunate in having had an unusually active voice in AMA affairs in recent years. Our delegates,* led by Reuben B. Chrisman Jr., are extremely competent in getting along with AMA people and thereby assure us superior representation. Several Florida physicians** serve ably on AMA councils and committees. Homer L. Pearson Jr., our member of the Board of Trustees, has been our able counselor and adviser for a long time. The late Louis M. Orr was our first AMA president and he proved to be capable, tireless and fearless. Then, illustrating democratic action at its height, our own Edward R. Annis was chosen president by demand of the membership. We, in Florida, had known of his abilities and utilized his talents for many years. It is fortunate for American medicine that Ed came along when he did and that he accomplished what he did. We are grateful to him, but he cannot do it all. We must provide interest and aid.

Our AMA is requesting a raise in dues. Our dues have long been less than those of any comparable group. Doubtless some raise is necessary, but we must familiarize ourselves with the related facts and let our wishes be known. We do not dare restrict the progress of our organization at this time.

We, in Florida, are fortunate in having still another close tie with our AMA. During recent years clinical and annual meetings have been held in our state. As you know, the Clinical Session and the House of Delegates are scheduled for Miami Beach, November 29 through December 2. Clinically the meeting is superb, and democratically it is our fault if each of us is not represented not only by our delegates but by ourselves. Let's attend.



*Meredith Mallory, Francis T. Holland, Burns A. Dobbins Jr., Jere W. Annis.

**Reuben B. Chrisman Jr., Committee on Maternal and Child Care; Committee on Disaster Medical Care. Burns A. Dobbins Jr., Council on Medical Service; Committee on Federal Medical Services; Committee on Maternal and Child Care. H. Phillip Hampton, Council on Legislative Activities; Committee on Indigent Care. Francis T. Holland, Committee on Communications; Council on Rural Health. Samuel P. Martin, Council on Postgraduate Programs; Chairman, Section on Experimental Medicine and Therapeutics. Mason Romaine III, Council on Voluntary Health Agencies. Clifford C. Snyder, Residency Review Committee for Plastic Surgery. Wilson T. Sowder, National Council on Accreditation of Nursing Homes. Edward H. Williams, Committee on Aging.



Editorials

Workmen's Compensation

We physicians already know that we have other people besides ourselves to consider in the problems of Workmen's Compensation: They are:

1. The worker
2. Industrialists
3. The insurance carrier
4. The legal profession
5. The state and taxpayers

Although the medical profession is beginning to have a strong voice in the affairs of Workmen's Compensation, we have not always had such. This could very well be largely our fault because of apathy. I know that on several occasions when I have attended the yearly conferences on Workmen's Compensation, practicing physicians have been very scarce at the meetings whereas lawyers have attended in abundant numbers even though lawyers see only those very few injuries which result in claims of litigation and doctors have to see all injuries. I believe it only fair to state, however, that we have had to push our way into recognition. This may be because the previous bureaucratic control has been jealous of its prerogatives and has excluded us at every unobtrusive opportunity.

The Workmen's Compensation law directly affects the medical profession because it sets our fees and supervises the method of payment. I will quote the paragraph which directly affects us:

> If an injured employee objects to the medical attendance furnished by the employer, it shall be the duty of the employer to select another physician to treat the injured employee unless the Commission determines that a change in medical attendance is not for the best interests of the injured employee; provided that the Commission may at any time, for good cause shown, in its discretion order a change in such remedial attention, care, or attendance. It shall be unlawful for an employer or representative of any insurance company or insurer to coerce or attempt to coerce a sick or injured employee in the selection of a physician, or surgeon or other attendant or remedial treatment, nursing or hospital care, or any other service that the sick or injured employee may require; and any employer or representative of any insurance company or insurer who violates that provision shall be guilty of a misdemeanor and upon conviction therefor shall be fined not less than twenty-five dollars and not more than one-hundred dollars for each and every offense.
>
> All fees and other charges for such treatment or service shall be limited to such charges as prevail in the same community for similar treatment of injured persons of like standard of living, and shall be subject to regulations by the Commission, who shall adopt schedules of charges for such treatment or services.

As you know, the Florida Medical Association has directed us to use the new Florida Relative Value Schedule in all future fee negotiations and we were able to do this in the present schedule. The Florida Industrial Commission and industry needed some persuasion on this point, but as usual after everybody understood, there was very little difficulty.

After that we were able to persuade the Industrial Commission to allow us to try the concept of not publishing the negotiated maximum fee schedule for the following reasons:

1. A maximum fee schedule soon becomes a minimum fee schedule.

2. We have already demonstrated through our experience with the federal Medicare for service dependents that by charging our regular fees we will have enough below-schedule charges to save money.

3. As in the past, industry, the patient and the insurance companies can quickly assess the value of doctors' services—to get the best medical service at the most consistently reasonable fees—and we doctors are all perfectly willing to compete for industrial work on this good old American principle.

4. Sufficient experience can be obtained in Tallahassee by IBM data to give insurance companies actuarial experience.

5. Our big hassle over a dual fee schedule can be resolved by every physician charging his own fee and letting attrition get him if he is consistently exorbitant. We all know that nobody should be paid more than anybody else for doing a simple procedure and getting the optimum result and our customers will ultimately find out about that.

Our first most important foothold for a voice in Workmen's Compensation matters was gained when Dr. Thomas J. Bixler of Tallahassee was named as Medical Consultant for the Florida Industrial Commission. He was a joint selection of the Florida Medical Association and the Industrial Commission and for the first time we had a true, sincere, honest and reliable representative of our profession available at all times. Mr. Brown, Commission chairman, has proved that Dr. Bixler's function is almost an indispensable portion of his administration.

The advisory status has been enlarged so that the Industrial Commission now has appointed a Medical Advisory Committee headed by Dr. Bixler. The members of this committee were selected from a list provided by the Board of Governors of the Florida Medical Association. An attempt has been made to represent the major specialties and the major areas of the state.

H. L. Harrell, M.D.
Ocala

The Biopsy

What is an adequate biopsy? It is one that yields the correct diagnosis. How much tissue is required? That depends on the lesion. A few cells from a pleomorphic undifferentiated tumor may suffice for an unequivocal diagnosis. The same number of cells from a well differentiated cancer may appear quite innocuous and be totally inadequate for diagnosis. Not all tumors are of uniform composition and a small biopsy from a well defferentiated area may provide erroneous information.

The most informative biopsies are excisional ones in which the entire lesion and surrounding normal tissues are removed by careful dissection. In such biopsies the relationship of the lesion to surrounding structures, the architectural pattern so important in the diagnosis of lymphomas, as well as the cytology of the lesion may be evaluated. The diagnoses so obtained are generally conclusive and the surgical procedure may be therapeutically complete in itself.

Such excisional biopsies are not always feasible or indicated. In their stead, incisional biopsy or aspiration needle biopsy may provide adequate samples. These alternatives do, however, have certain inherent deficiencies and limitations.

Incisional biopsy is generally adequate and is ideal for large lesions of the skin or mucous membranes, but results in contamination of the biopsy site and possible compromise of the prospective surgical field. The latter risk is particularly great when this biopsy technique is employed for more deeply seated lesions such as many of those which present in the neck.

Aspiration biopsy yields a small sample that is more difficult to handle and interpret, that is less likely to be representative of the lesion as a whole, and which if negative is inconclusive. Aspiration biopsy also is a blind procedure that is not without hazard in itself. Contamination of the surgical field is likely to be less extensive than with incisional biopsy; however, tumor may seed along the needle track or tracks which must be excised at the time of definitive surgery.

The risk of provoking tumor dissemination by biopsy prior to definitive surgery can be minimized by keeping the interval between the two as short as is practical. This depends on close cooperation between the surgeon and pathologist. Permanent paraffin sections can easily be ready for reporting within 24 hours, while the use of quick frozen sections can virtually eliminate any delay. The advent of the cold blade refrigerated microtome (cryostat) has dispelled much of the mysticism associated with the preparation and interpretation of quick sections, and now, a competent technician can readily prepare quick sections that are equal in quality to permanent paraffin sections and are eminently suitable for immediate accurate interpretation.

Biopsy, once elected, has three essential requirements. First, it should provide a representative sample of the lesion in question, sufficient for a conclusive diagnosis. Second, the biopsy site should be placed so that it may be excised with the lesion, without compromise of the surgical field, at the time of subsequent definitive surgery. Third, it should be performed at as short an interval prior to the definitive surgical procedure as is practical.

Biopsy is an indispensable aid in the diagnosis and treatment of cancer. Various biopsy techniques are available to the surgeon. Each has an appropriate application. Selection of the optimum procedure depends on sound surgical judgment.

C. Ian Hood, M.D.
Gainesville

Surgical Treatment of Duodenal Ulcer

The recent surgical literature has been filled with articles and editorials arguing the merits of various forms of gastrectomy versus vagotomy combined with a drainage procedure in the treatment of duodenal ulcer. The meat of the argument lies in two areas: (1) the ultimate results as manifested by relief of pain, recurrent ulcer, anastomotic ulcer, hemorrhage and other conditions, and (2) the morbidity and mortality associated with dissection of the duodenum.

As far as the former is concerned, it is probably too early to assess the ultimate results from vagotomy with pyloroplasty or gastroenterostomy, although leading surgeons advocating these procedures claim results comparable to those of gastrectomy. In my hands, certainly, the drainage procedures have so far been very acceptable though mine is a small surgical practice.

This editorial is largely concerned with discussion of dissection of the duodenum. Mortality from gastric resection has been quoted as varying from 0.9 to 3.6 per cent in recently published series. The mortality must be at least 5 per cent in many other series unpublished since few write papers advertising their mediocrity. A 5 per cent, or even 3 per cent, mortality is too high in the treatment of duodenal ulcer, a benign disease. The mortality in vagotomy and pyloroplasty or gastroenterostomy should approach zero in competent hands. In my opinion, this single reason is enough to tip the scales against gastrectomy. The morbidity is certainly much higher with gastrectomy. Even in completely uncomplicated cases, the patients are much more ill and for a longer period of time.

I do not believe the master surgeons of this country do anything to help the patient with duodenal ulcer when they write so glibly of gastrectomy and particularly with removal of the duodenal ulcer, or catheter duodenostomy on the difficult stump. A few years ago I asked one of the country's best known elder surgeons if he removed the ulcer from the duodenum at gastrectomy. His public answer was, "Always." I said to myself at that time, "Any young surgeon who heard that remark is in for some serious trouble, not to mention his patient." Anyone who dissects out or around enough duodenal ulcers is going to get into trouble with a leaking stump or pancreatitis. This is learning the hard way. Catheter duodenostomy is a fine procedure when nothing else can be done, but it is not something to be done without a chill of apprehension.

In my opinion, at the present time, all patients with duodenal ulcer needing surgery should be considered for vagotomy with pyloroplasty or gastroenterostomy; and gastrectomy in any form should be reserved for gastric ulcer, tumors, or recurrent or persistent ulcer after vagotomy with drainage. I have been fortunate to have had no patient needing further surgical treatment so far. It seems logical, however, that an antrectomy could be performed without too much difficulty on a patient in whom complications develop after the safer and less shocking procedure of vagotomy with drainage.

GEORGE M. STUBBS, M.D.
JACKSONVILLE

FLORIDA MEDICAL ASSOCIATION ORGANIZED 1874

Association News

Summary of Board of Governors' Meeting September 24-26, 1964

Annual Meeting 1965.—Approved recommendation of the Scientific Work Committee and adopted format for the 1965 Annual Meeting, April 22-25, 1965 which included scientific color TV presentations. (Americana, Miami Beach.)

January 1965 Meetings.—Approved the dates of January 9 and 10, 1965 for the Executive Committee and Board of Governors meetings in Jacksonville and January 23 and 24, 1965 for the Conference of Presidents and Secretaries of county medical societies in Orlando.

Corporate Practice.—Approved the report as presented by the Judicial Council regarding the corporate practice of medicine and directed that the policy be sent to every member of the Florida Medical Association.

Inter-American Relations.—Approved the report of the Subcommittee on Inter-American Relations including the FMA participation in the Hope project at Cuenca, Ecuador.

Statement of Policy.—Adopted the following statement of policy: "That recommendations and legislative proposals dealing with health matters by representatives of the Florida Medical Association, its component county medical societies, recognized specialty groups and individual members be cleared through or coordinated with the appropriate officer, council or committee of the FMA."

Educational Advertising.—Reviewed the FMA-AMA educational advertising campaign to carry an advertisement in every daily and weekly newspaper in Florida in October regarding medical assistance to the needy.

Mental Health.—Considered the recommendations regarding a Division of Mental Health referred by the House of Delegates and proposals by the Interim Legislative Committee of the Florida Legislature and adopted

specific recommendations regarding Mental Health and Mental Retardation. (This policy has been mailed under separate cover.)

Medicolegal Code—Amended and adopted a proposed Florida Professional Medicolegal Code for final adoption in conjunction with the Florida Bar.

Pharmacy.—Requested county medical societies to take leadership in establishing local interprofessional committees with pharmacists in their areas.

Blue Shield.—Reiterated that the 1962 Relative Value Studies be adhered to and applied to the $7,500 income level Blue Shield contract when issued and the high level federal employees' contract.

Tetanus.—Approved recommendation that county medical societies and health departments study the incidence and death rate of tetanus to determine where they stand in relation to other counties and consider development and co-sponsorship of appropriate community-wide tetanus immunization programs for all age groups in their respective counties.

Venereal Disease.—Recommended improved reporting by physicians to the health departments of venereal disease cases, particularly infectious primary and secondary syphilis, and improved and augmented efforts in carrying out educational programs, especially in schools.

FMA Investment Plan.—Reviewed the status and the progress of the FMA Investment Plan and a summary statement of participation.

Drug Repackaging.—In answer to an inquiry, advised that the Association is not aware of any information regarding any drug repackaging house which has a deleterious effect on the general public or on the good reputation of the doctors of Florida.

Medical Scholarships.—Reviewed the resolution referred by the House of Delegates regarding medical scholarships and recommended that it not be implemented by a special tax on physicians and that the Committee on Physician Placement review the present scholarships and loans available and make recommendations to the Board.

Other Reports.—Reviewed numerous other reports of Councils and Committees and took appropriate action where necessary.

Meetings

November

Southeastern States Cancer Seminar, November 11-12, Hotel Robert Meyer, Jacksonville

Florida Pediatric Society, Annual Fall Meeting, November 12-14, Colony Beach Resort, Sarasota

Florida Urological Society, Fall Meeting, November 13-14, Parliament House, Clearwater Beach.

American Medical Association, Clinical Convention, November 29-December 2, Americana Hotel, Bal Harbour

December

Second Annual Seminar in Cardiology, "Diagnostic Methods in Cardiology," December 3-6, Tampa General Hospital, Tampa.

Seminar in the Present Status of Amputation Surgery and Prosthetics, December 3-5, Americana Hotel, Bal Harbour, Fla.

January

Gastroenterology Seminar, January 14-16, University of Florida College of Medicine, Gainesville.

Pediatric Seminar, "Current Concepts in Allergy and Clinical Immunology in Childhood," January 21-23, University of Florida College of Medicine, Gainesville.

"Respiration," Second Annual Postgraduate Seminar, January 22-25, Eden Roc Hotel, Miami Beach. Sponsored by University of Miami School of Medicine and University of Florida College of Medicine.

Seventh Annual Conference, County Medical Society Presidents and Secretaries, January 23-24, Robert Meyer Motel Hotel, Orlando.

News

The interim meeting of the Florida Urological Society will be held at the Parliament House at Clearwater Beach on November 13-14. Dr. Harry Grabstald, Assistant Professor of Urology at Cornell University Medical College, New York City, will be the guest speaker.

The 1964 Southeastern States Cancer Seminar is scheduled for November 11-12 at the Hotel Robert Meyer in Jacksonville. Sponsoring organizations include the Florida Division of the American Cancer Society, Florida State Board of Health and the Duval County Medical Society. The Seminar is approved for 14 hours credit by the American Academy of General Practice.

The North Florida Pathologists' Association will hold its regular meeting at 5:00 p.m., Thursday, November 19, in Room M-623, Basic Science Building, University of Florida College of Medicine, Gainesville. The program consists of a slide seminar moderated by Dr. David B. Jones, Professor of Pathology, State University of New York, Upstate Medical Center at Syracuse. Dr. Jones is recognized for his research on the ultrastructure of the human glomerulus and its relation to various disease states.

Dr. F. William Sunderman Jr., formerly associate in medicine at Jefferson Medical College of Philadelphia, has been appointed Associate Professor of Pathology and Director of Clinical Laboratories at the University of Florida College of Medicine.

The first area conference for health insurance and utilization problems was held in St. Petersburg on August 3 under auspices of the Pinellas County Medical Society. Dr. David J. Lehman Jr. of Hollywood, Chairman of the Committee on Health Insurance of the Florida Medical Association, was one of the principal speakers.

The first of three 1965 sectional meetings of the American College of Surgeons will be held in Atlanta on January 25-27. The Atlanta Biltmore is the headquarters hotel.

Delegates from Florida to the annual meeting of the Association of American Physicians and Surgeons which began October 8 at New Orleans

include Drs. James L. Anderson, Ralph W. Jack and Walter W. Sackett Jr. of Miami; Dr. Fred Mathers of Orlando, and Dr. Robert J. Needles of St. Petersburg.

The annual meeting of the Southern Medical Association is scheduled for November 16-19 in Memphis, Tenn.

The Second Annual Postgraduate Seminar, "Respiration," has been scheduled for January 22-25, 1965, in the Eden Roc Hotel at Miami Beach. The Seminar is sponsored by the University of Miami School of Medicine and the University of Florida College of Medicine.

The Sixth National Conference on the Medical Aspects of Sports sponsored by the American Medical Association under the auspices of the AMA Committee on the Medical Aspects of Sports will be held in the Deauville Hotel at Miami Beach on November 29.

Deaths

Cullen, Marvin LeRoy, Tampa; born in Woodward, Okla., on Feb. 3, 1919; University of Oklahoma School of Medicine, Oklahoma City, 1943; served an internship in the Jersey City Medical Center, Jersey City, N. J.; served with distinction in the Medical Corps of the United States Army during World War II; upon discharge from military service, served a residency in general surgery until 1947 at the Veterans Hospital, Atlanta, and then had training in plastic surgery for two years; re-enlisted in the Medical Corps of the United States Army in 1951 and served as head of the plastic surgery department of the Army hospital in Tokyo during the Korean War; since late 1952 had practiced in Tampa; was a member of the American Medical Association, Southern Medical Association, Florida Society of Plastic and Reconstructive Surgery and Florida Association for Cleft Palate Rehabilitation; died January 13, aged 44.

Jobson, Alexander Mettauer Charles, Temple Terrace; born in Macon, Ga., on Aug. 31, 1890; Tulane University School of Medicine, New Orleans, 1915; served an internship at Jefferson Hospital, Roanoke, Va., and later engaged in postgraduate study at Tulane University, Mayo Clinic, Columbia University, University of Vienna and Heidelberg University; soon after entering private practice in Bartow, joined the Medical Corps of the United States Army in 1917, serving in France during World War I and in Germany with the Army of Occupation; entered the practice of surgery and gynecology in 1921 in Tampa in association with the late Dr. John S. Helms; was a former vice president and a life member of the Florida Medical Association; was a life member of the American Medical Association, the American College of Surgeons and the Hillsborough County Medical Association; was a certified fellow of the International College of Surgeons, a fellow of the Southeastern Surgical Congress and a member of the Pan-Pacific Surgical Association; died February 15, aged 73, of necrosis of the liver.

Reeves, John Dudley Jr., Gainesville; born in Fort Worth, Texas, 1924; University of Arkansas School of Medicine, Little Rock, Ark., 1947; limited his practice to radiology; had for three years been a full time member of the faculty of the University of Florida College of Medicine, Gainesville; was a member of the American College of Radiology and served on its Commission on Administrative Structure in 1959; was chairman of a special committee of radiologists, physicists and geneticists working to establish the limits of radiation exposure to patients, particularly pregnant women and women in the child-bearing age; was co-chairman of the Sub-Committee on Radiological Aspects of Disaster Planning, whose published report was awarded the Certificate of Merit by the American Society of Association Executives; was also a member of the American Medical Association, American Roentgen Ray Society, Radiological Society of North America and American Radium Society; was elected an alternate delegate to the International Congress of Radiology to be held in Rome in September 1964; died March 6, aged 39.

Rudisill, Clarence Astor, Tampa; born in Atlanta, Ga., on Oct. 10, 1900; University of Texas Medical Branch, Galveston; interned at St. Jo-

seph's Infirmary, Fort Worth; entered general practice in Tampa in 1926 and 10 years later limited his practice to general surgery, retiring in 1959; held membership in the American Medical Association; died March 7, aged 63.

Young, Clifton Aurelius, Clearwater; born in Clearfield, Pa., on April 25, 1894; Jefferson Medical College, Philadelphia, 1923; interned at Graduate Hospital, University of Pennsylvania, Philadelphia, served residencies in ophthalmology and otolaryngology at Washington Naval Hospital, Washington, D. C., Memphis Eye, Ear, Nose and Throat and Memphis City hospitals, Memphis, Tenn., Grady Hospital, Atlanta, Ga., and Polyclinic-Post-Graduate Hospital, New York City, and engaged in additional postgraduate studies at Lempert Institute of Otology, New York City, in otology, and University of Illinois College of Medicine, Chicago, in bronchology; served in the United States Army during World War I and served in the Medical Corps of the United States Navy from 1924 to 1953, when he was retired with the rank of captain because of physical disability; had engaged in the private practice of ophthalmology since that time, first in Dunedin for five years and thereafter in Clearwater; held membership in the American Medical Association, Military Association of Surgeons, American Public Health Association, and Florida Society of Ophthalmology and Otolaryngology, and was a fellow of the American College of Surgeons and American Academy of Ophthalmology and Otolaryngology; died of myocardial infarction on March 20, aged 69.

Morton, Arthur Oscar, Sarasota; born in St. Albans, Vt., in 1876; University of Vermont College of Medicine, Burlington, Vt., 1899; was assistant physician at Massachusetts Hospital for Epileptics, Palmer, Mass., from 1899 to 1907 and had other postgraduate work at New York Lying-in Hospital, Graduate Hospital and New York Eye and Ear Infirmary in New York City, Harvard Medical School, Boston, and the University of Vienna, Vienna, Austria; engaged in the general practice of medicine at St. Albans from 1907 to 1921 and thereafter in Sarasota until he retired; was a past president of the Sarasota County Medical Society and was honored by that society for 61 years of medical practice from 1899 to 1960; was active in the founding of the first Sarasota City Hospital; held membership in the American Medical Association; died January 4.

Chapman, John Foster, West Palm Beach; born in Andalusia, Ala., on July 26, 1916; Emory University School of Medicine, Atlanta, Ga., 1942; interned at Grady Memorial Hospital, Atlanta, served as a commander in the United States Navy during World War II; served residencies from 1946 to 1948 at Grady Memorial and Crawford W. Long hospitals, Atlanta; had engaged in the practice of obstetrics and gynecology in West Palm Beach since 1948; was a founder and first president of the local Cancer Clinic; held membership in the American Medical Association; died April 9, aged 47.

Jackson, J. Garrett, Orlando; born in Chester, W. Va., on July 9, 1905; University of Arkansas, Little Rock, 1931; interned at Charity Hospital, New Orleans, and served residencies at Harris Hospital, Ft. Worth, Tex., and Crippled Children's Hospital, Little Rock; engaged in general practice in Welek and Mullins, W. Va., before serving for one year as assistant superintendent of the Kentucky State Hospital, Louisville; in 1942, joined the staff of the Florida Tuberculosis Hospital, Orlando, and in 1945 entered the private practice of general medicine, with emphasis on pulmonary disease, in Orlando; was a veteran of World War II; held membership in the American Medical Association and the Southern Medical Association; died July 18, aged 59.

Lawler, Harold Thomas, Sarasota; born in Peoria, Ill., on Dec. 21, 1916; St. Louis University School of Medicine, St. Louis, Mo., 1941; interned at St. Francis Hospital, Peoria; was in the Medical Corps of the United States Army from 1942 to 1946, attaining the rank of major and concluding his military service in the Far East; entered the general practice of medicine in Peoria in 1946 and since 1950 had continued his practice in Sarasota; was a member and in 1962 the president of the Sarasota County Medical Society; held membership in the American Medical Association; died April 15, aged 47, of acute coronary thrombosis.

Luppold, Luther Samuel, Miami; born in Reading, Pa., on Aug. 21, 1897; Temple University School of Medicine, Philadelphia, 1921; served an internship at Harrisburg General Hospital, Harrisburg, Pa.; engaged in the general practice of medicine in White Haven, Pa., for 28 years, and in Miami since 1952; held membership in the American Medical Association; died March 26, aged 66.

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Side Effects and Precautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Dosage—The usual adult dosage is one tablet of 15 mg. with meals and two at bedtime; this amount may be doubled or tripled for patients with severe conditions. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

SEARLE

Chicago, Illinois 60680

Research in the Service of Medicine

1. Roach, T. C.: Therapy of Peptic Ulcer, J. Louisiana Med. Soc. *115*:136-139 (April) 1963.
2. Steinberg, H., and Almy, T. P., Drugs for Gastrointestinal Disturbances, Chapter 21, in Modell, W. (editor): Drugs of Choice —1964-1965, St. Louis, The C. V. Mosby Company, 1964, p. 343.

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Contraindications: Hyperexcitability, hyperthyroidism.

Before prescribing, see SK&F Product Prescribing Information.

Supplied: Bottles of 50 capsules.

1. Dorfman, W., and Johnson, D.: *Overweight Is Curable*, New York, The Macmillan Company, 1948, p. 16.

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Each 5 cc. (1 tsp.) contains:
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Robitussin with antihistamine and codeine

Each 5 cc. (1 tsp.) contains:
Glyceryl guaiacolate 100 mg.
Pheniramine maleate 7.5 mg.
Codeine phosphate 10.0 mg.
(Warning: may be habit forming)
Alcohol 3.5 per cent

Robitussin is indicated in coughs associated with head and chest colds, bronchitis, laryngitis, tracheitis, pharyngitis, pertussis, "flu," "grippe," measles, chronic paranasal sinusitis, pulmonary tuberculosis, or smoking. Robitussin A-C is especially indicated for allergic, harsh or unresponsive coughs.

dosage: ADULTS—1 tsp. every 3 to 4 hours. CHILDREN—½ tsp. every 3 to 4 hours.

side effects: No serious side effects from glyceryl guaiacolate have ever been reported. Nausea, G-I upset, and drowsiness may be encountered rarely with Robitussin A-C.

precautions: There are no contraindications for Robitussin. Robitussin A-C is contraindicated in patients hypersensitive to antihistamines or codeine.

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antihistaminic / antitussive

Each 5 cc. (1 tsp.) contains:
Dimetane® (brompheniramine maleate) 2 mg.
Phenylephrine hydrochloride 5 mg.
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Glyceryl guaiacolate 100 mg.
Alcohol 3.5 per cent in a palatable, aromatic base.

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Codeine phosphate 10 mg.
(Warning: may be habit forming)
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Alcohol 3.5 per cent in a palatable, aromatic base.

Indicated for relief of cough and allergic states in which an expectorant action is useful. Dimetane Expectorant-DC is indicated when the cough suppressant action of codeine is desired.

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side effects: Overdosage may result in mild drowsiness or excitement, but within the therapeutic range neither is likely.

Precautions: Administer with caution to patients with cardiac or peripheral vascular diseases and hypertension.

contraindications: Hypersensitivity to antihistamines or codeine. Not recommended for use during pregnancy.

references:* Boyd, E. M., and Ronan, A. K.: Am. J. Physiol., 135:383, 1942.

CLASSIFIED

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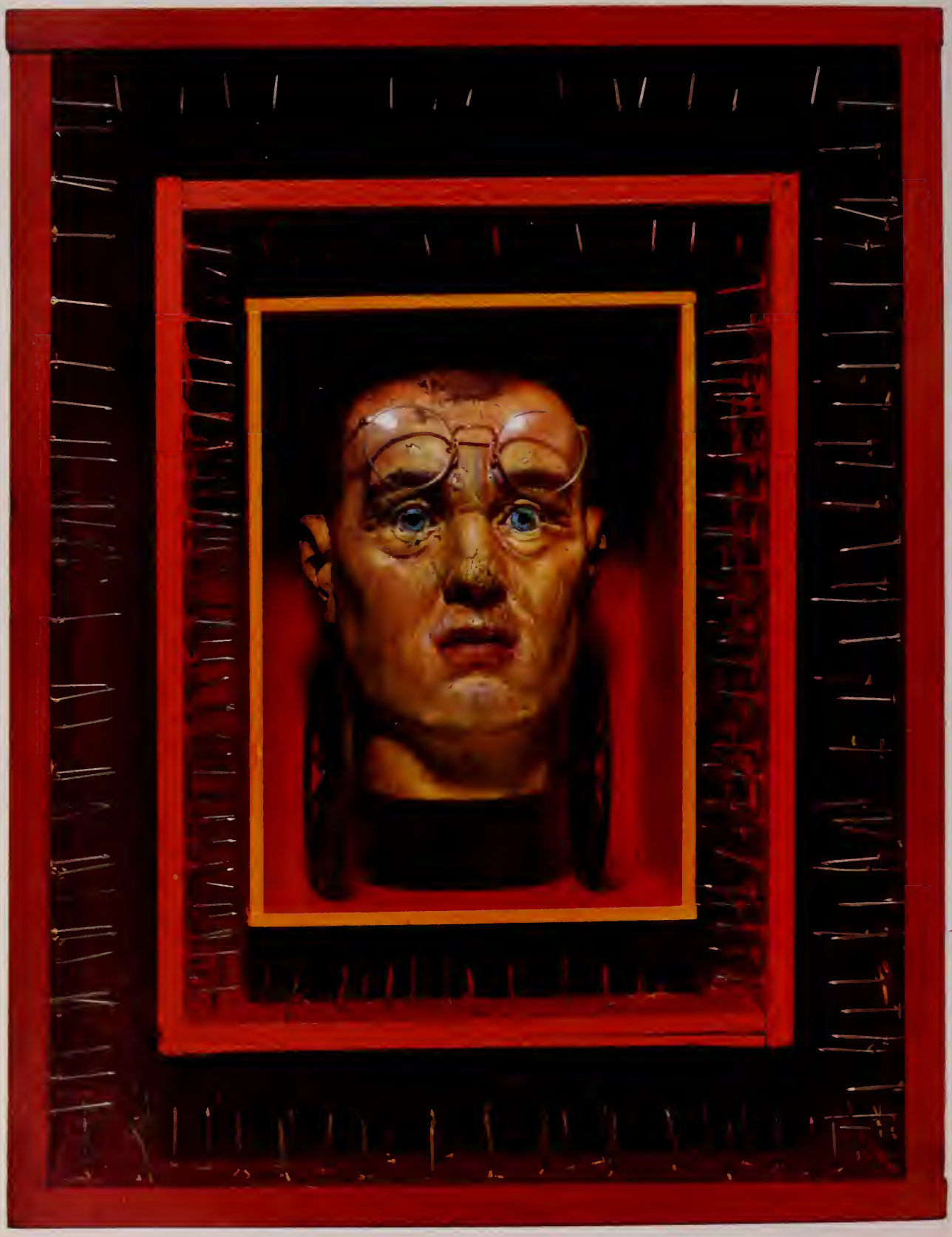
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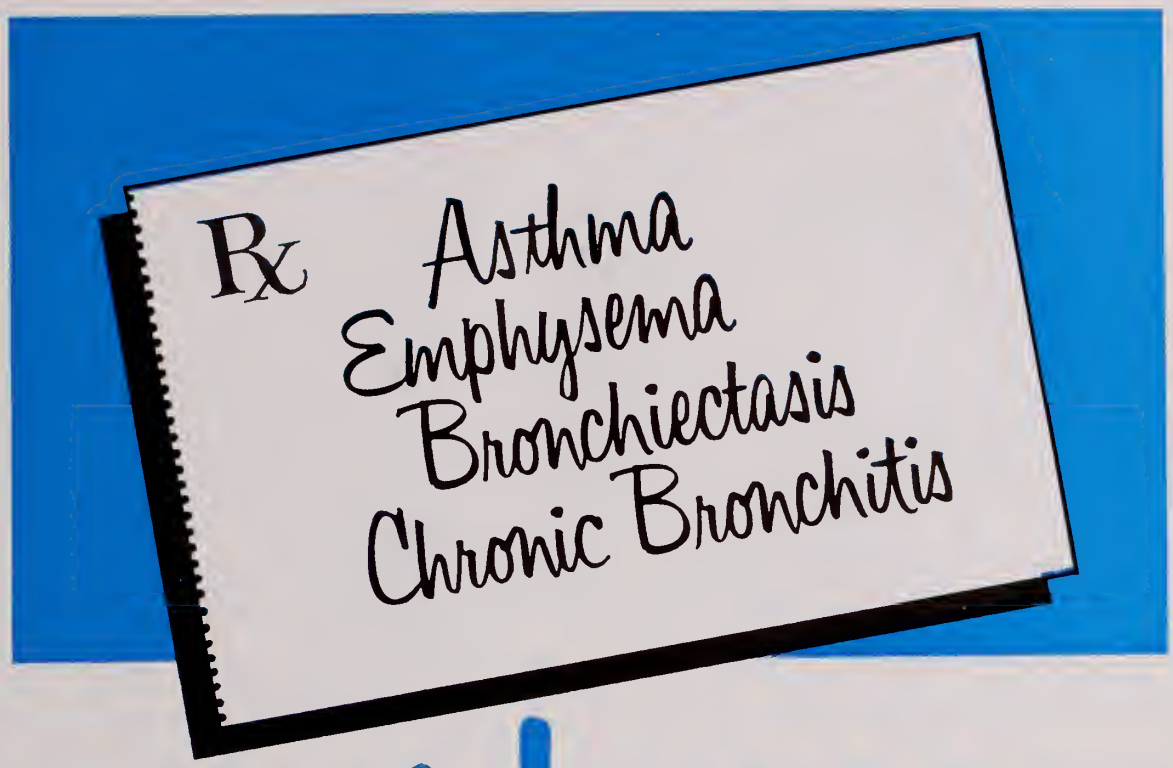
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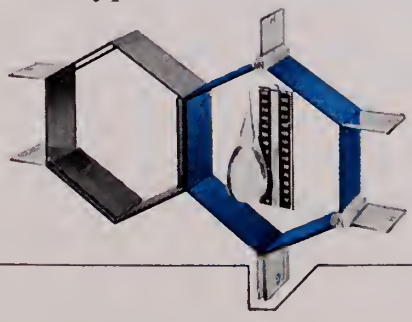
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1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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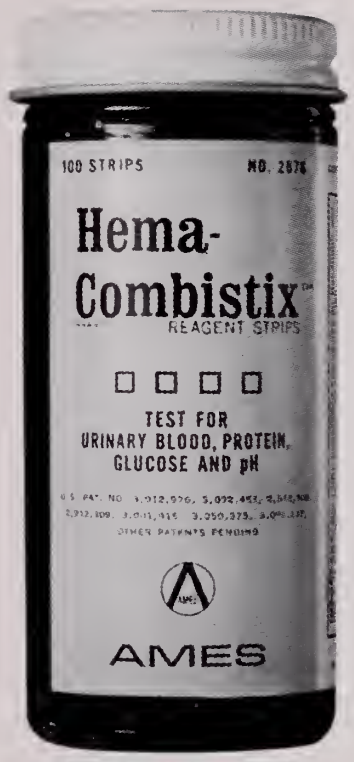
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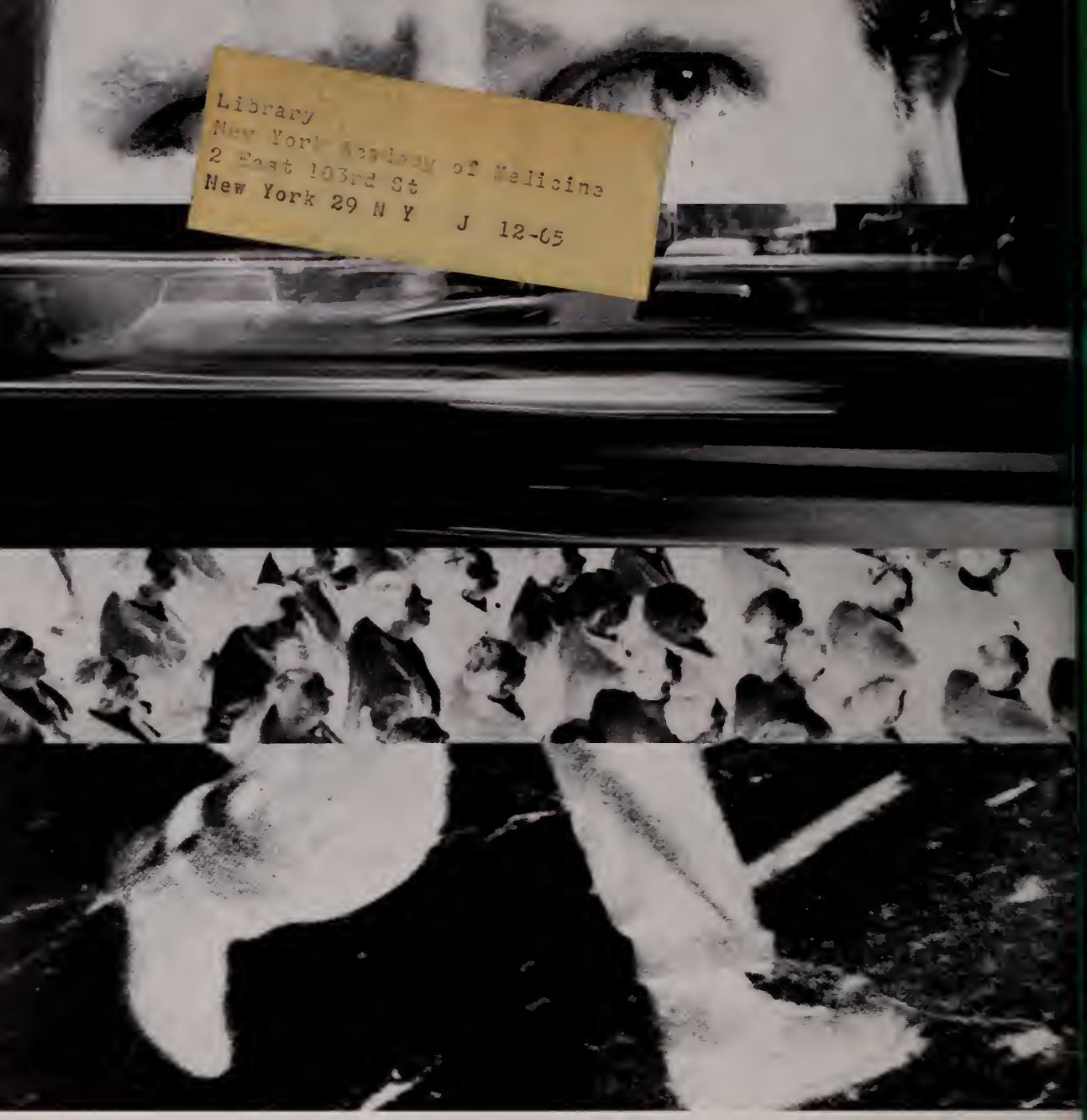
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TREATMENT OF EXTRAPYRAMIDAL EFFECTS

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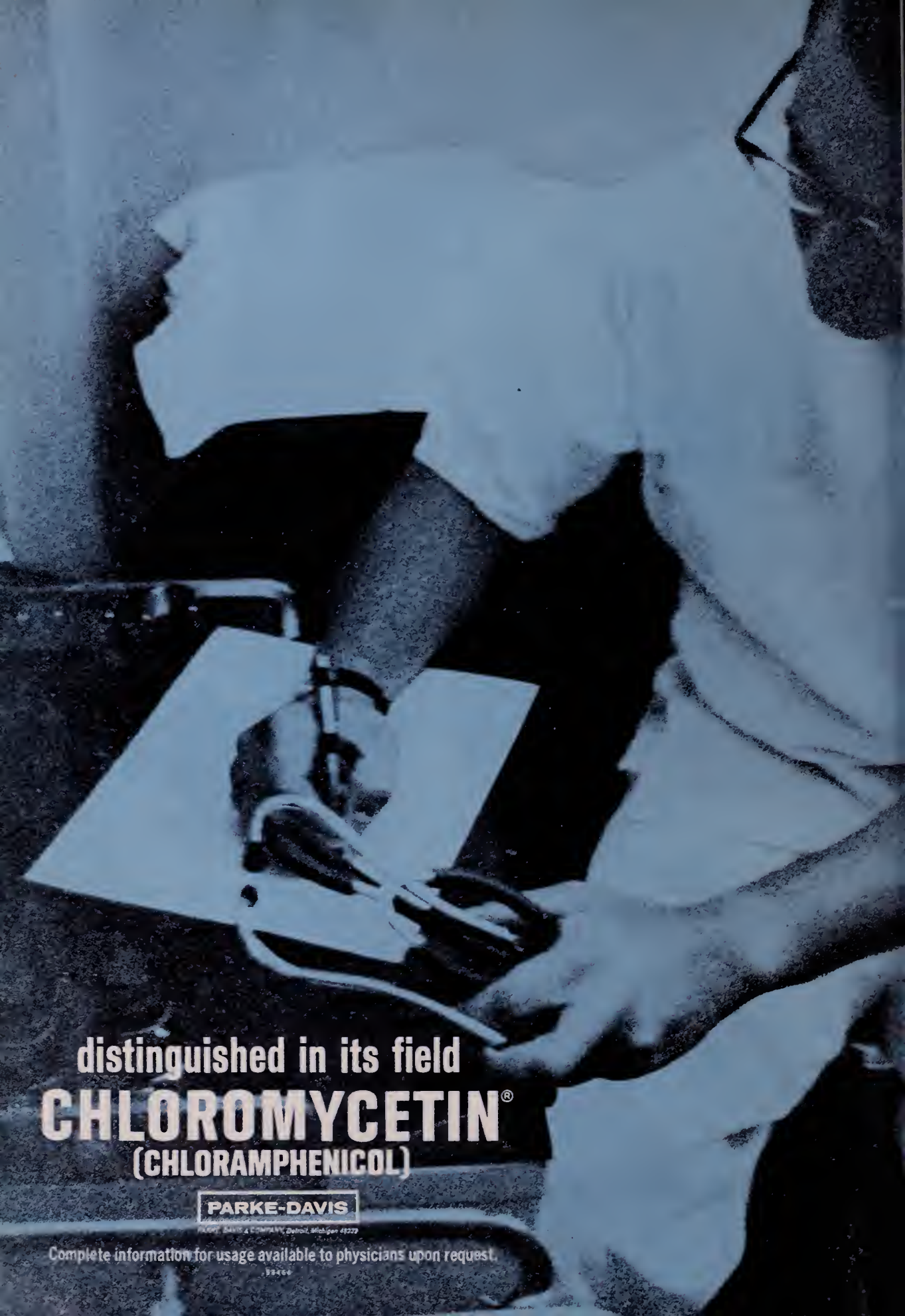
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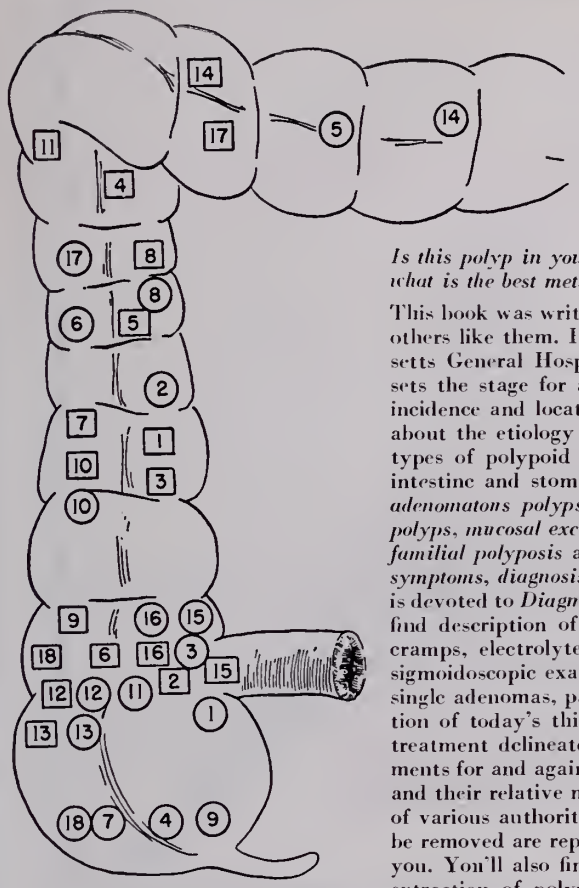


Figure 3-25. *Location of cancer and simple adenomas in resected cancers of the right colon. Squares locate cancers; circles, adenomas.*

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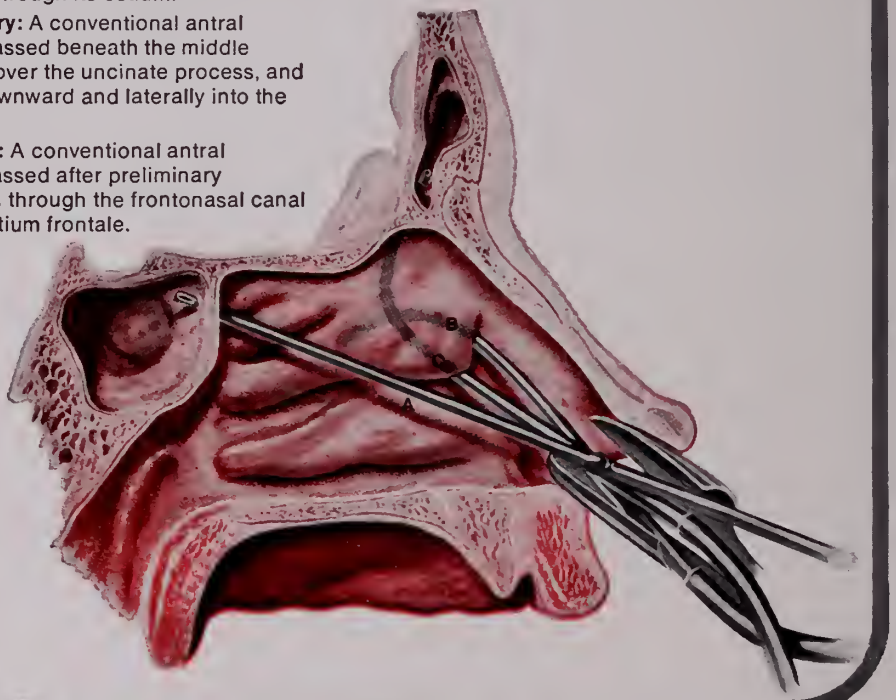
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Volume 51, Number 12, December 1964

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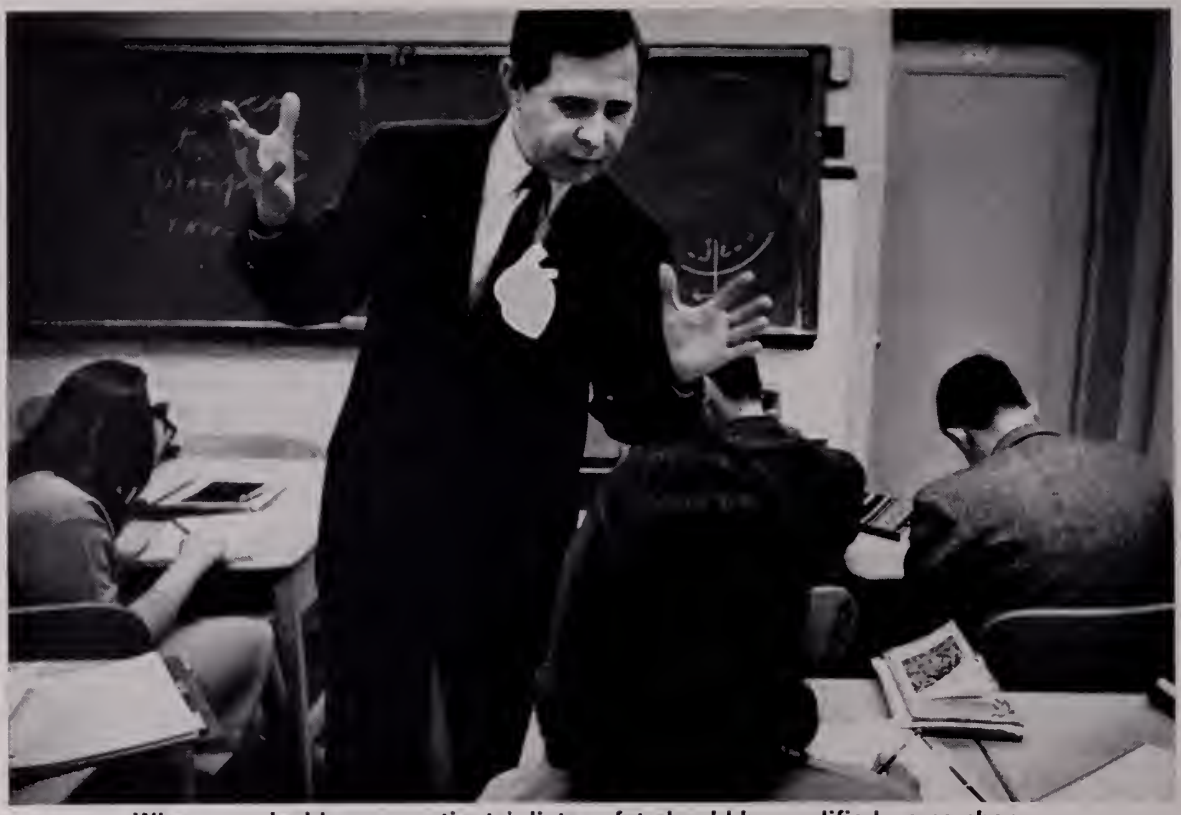
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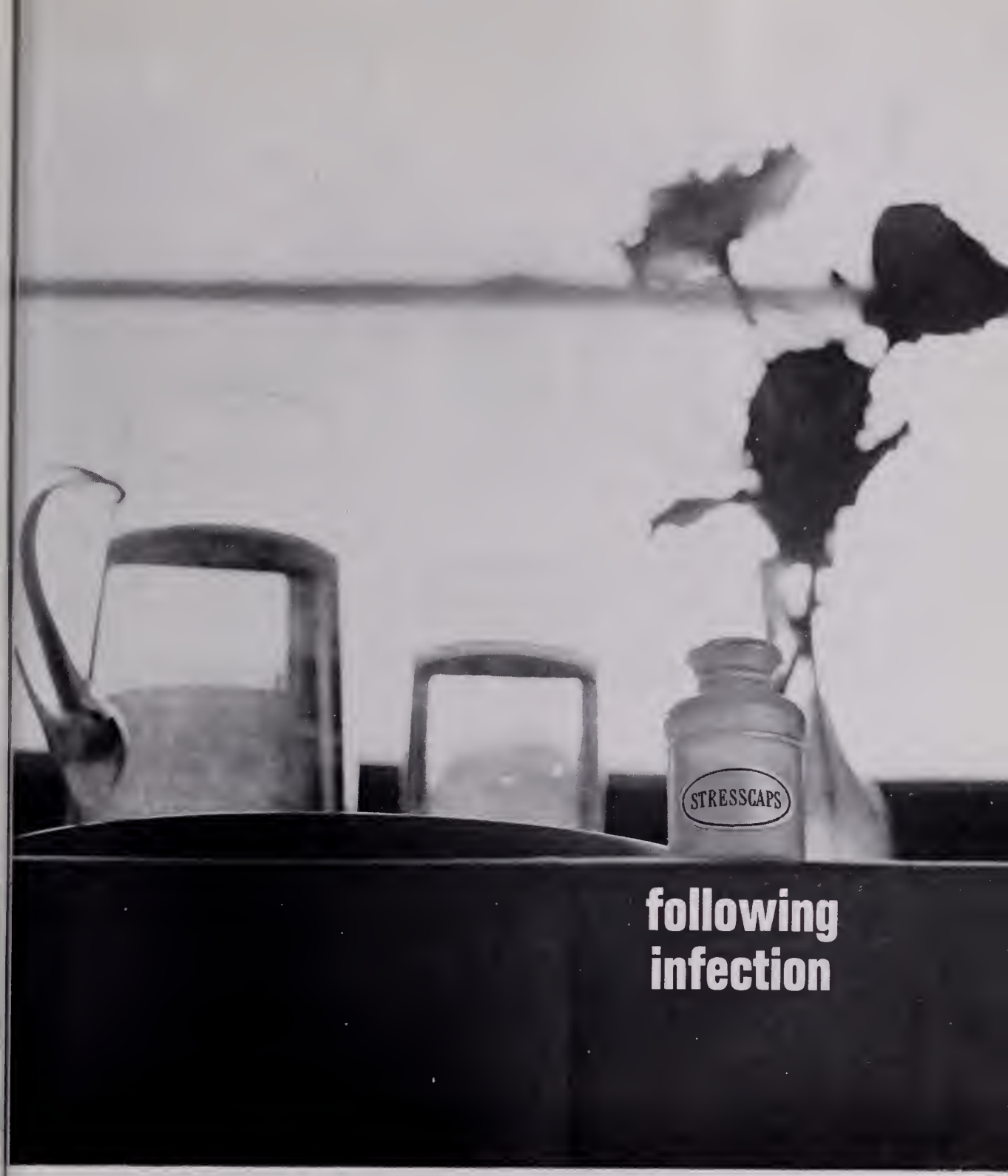
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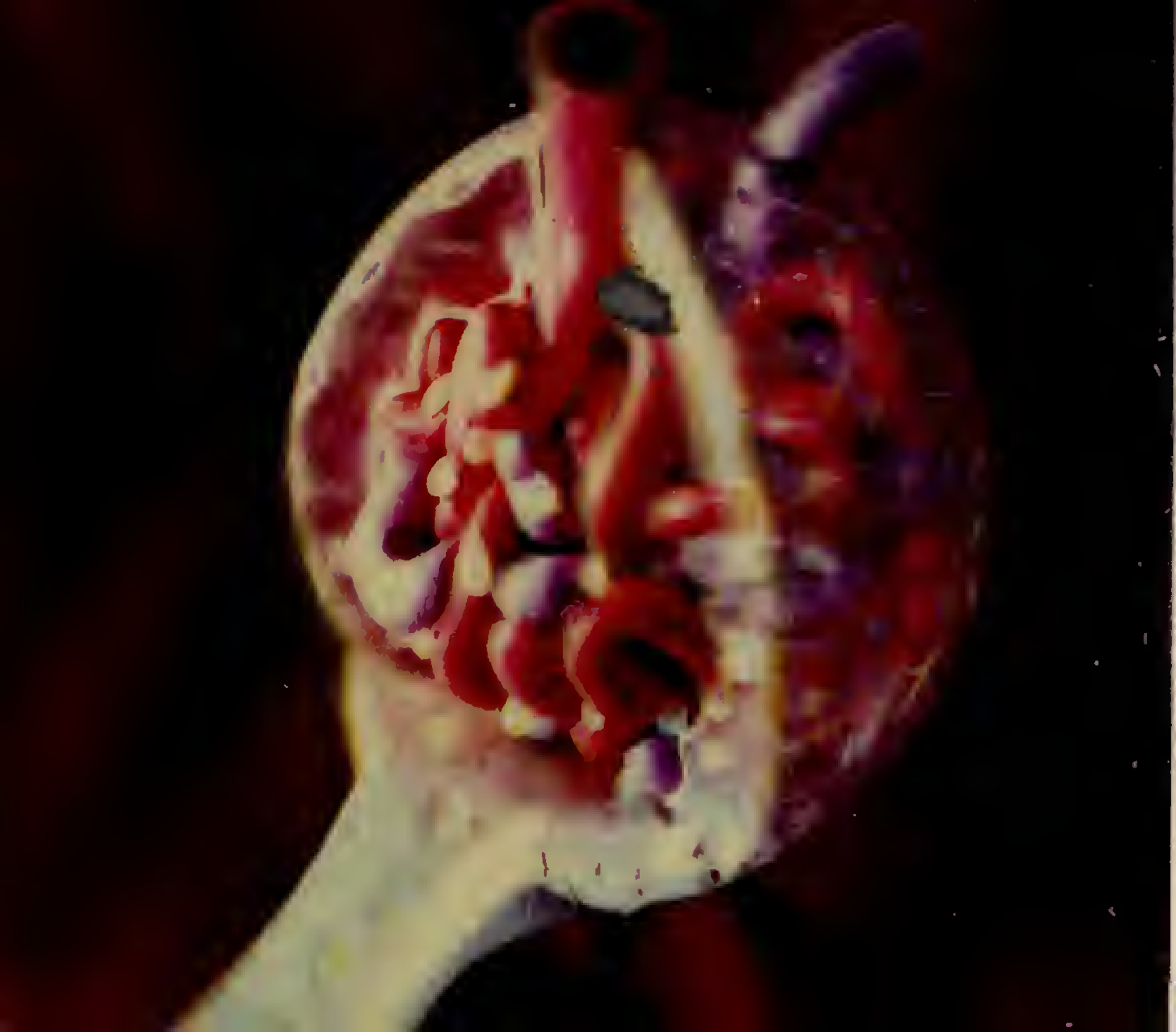
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1. Kunin, C. M., Dornbush, A. C. and Finland, M.: J. Clin. Invest. 38:1950, Nov., 1959.



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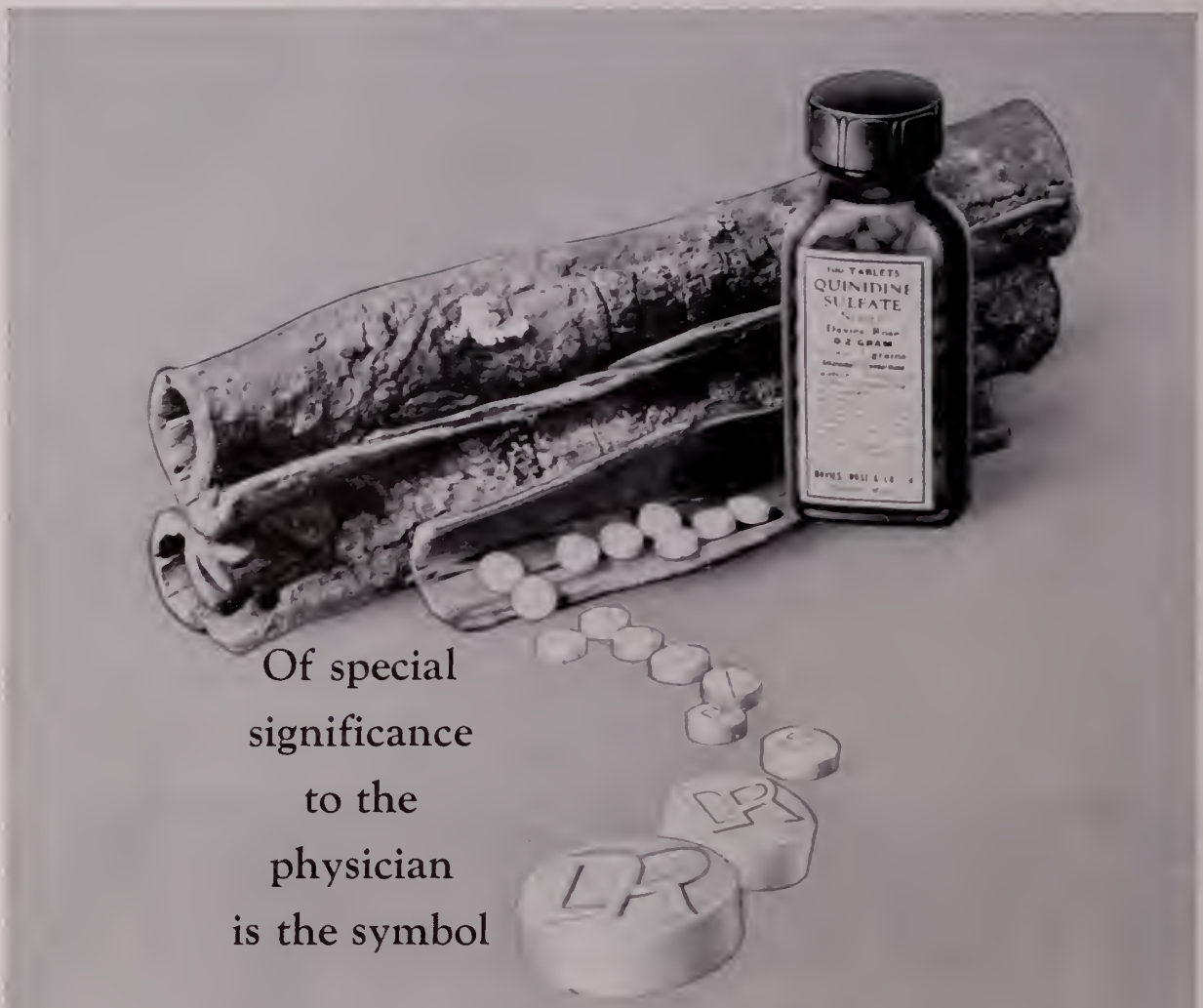
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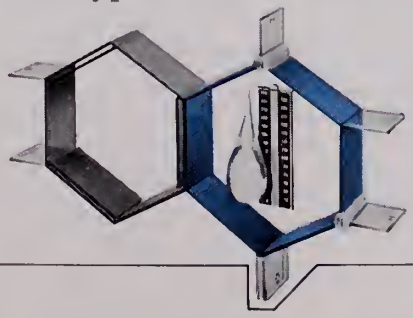
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1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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Prophylactic Treatment of Phenothiazine-Induced Extrapyramidal Effects

Burton J. Goldstein, M.D.
James A. Jordan, M.D.
and Benjamin Coleman, M.D.
MIAMI

In the past 12 years, the number of phenothiazines in current psychiatric use has grown to at least 16[6] not counting the hundreds of experimental compounds which have never been released by the pharmaceutical industry. Although these drugs have assumed major importance in psychiatric treatment, varying side effects have been observed since their inception. Among the adverse reactions noted, those affecting the extrapyramidal system, and resulting in Parkinson-like syndromes, dystonic reactions, and akathisia, are common and of major concern to the practitioner.[2,3,7,10]

In a search for more therapeutically potent phenothiazines, the basic phenothiazine structure has been altered in many ways. It appears that chemical alterations at two key locations on the phenothiazine molecule are intimately involved in the production of antipsychotic effect as well as being both necessary and sufficient to produce extrapyramidal symptoms. The addition of a dimethylamino grouping at position 10 and a chlorine molecule at position 3 results in chlorpromazine,[6] one of the earlier compounds. It was subsequently found that increased therapeutic potency could be obtained if a piperazine complex were substituted for the dimethylamino group at position 10. Further modification of the basic phenothiazine nucleus at position 3 was also noted to influence the drug's therapeutic activity as well as its degree of toxicity. The increase in therapeutic effectiveness, however, appears to be accomplished at the expense of increased production of extrapyramidal symptoms,[10] although the mechanism of this relationship is unknown.

The treatment of the neurological side effects has been variable, ranging from no treatment to intensive pharmacological intervention.[10,11,13,15-17]. In patients with dsytonic reactions the parenteral administration of an antiparkinsonian drug has been reported as offering rapid and efficacious treatment.[10]

The reduction of the dosage of the phenothiazine has been advocated in the treatment of parkinsonian and akathisia. In other cases antiparkinsonian medication is started when it is thought that reducing the dosage of the phenothiazine either is not practical or the patient's symptoms are severe enough to warrant an antiparkinsonian drug. Goldman[10] stated in a recent paper that "the management of drug parkinsonism in the treatment of psychotic illness can be divided into two elements: prevention of the occurrence of such manifestations, and treatment of the manifestations as they occur." It is our opinion that in certain types of treatment facilities there is a need for and there is an advantage in trying to prevent the occurrence of the extrapyramidal side effects. Goldman[10] pointed out that prevention of extrapyramidal side effects could be accomplished by the use of drugs which are therapeutically active and possess a low potency to produce side effects. Since, however, current phenothiazines apparently show a direct relationship between their antipsychotic effect and the production of neurological side effects, the more parsimonious approach would appear to be the in-

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stitution of concurrent antiparkinsonian treatment as a prophylactic measure. The present study is an evaluation of the effects of such a prophylactic approach.

Method

In order to determine the efficacy of concurrent use of antiparkinsonian drugs with phenothiazine medication a clinical study was undertaken, using a double-blind technique. Benztropine methanesulfonate (Cogentin) and a placebo in conjunction with various phenothiazines were clinically evaluated in a total of 83 patients. Patients who were hospitalized in the Jackson Memorial Hospital Institute between March 1, 1962 and June 1, 1962 were admitted to this study, if one of the phenothiazines was prescribed in at least the daily dosage of: thioridazine (Mellaril) 400 mg., chlorpromazine (Thorazine) 400 mg., perphenazine (Trilafon) 32 mg., trifluoperazine (Stelazine) 8 mg., or combinations of these drugs if the proper dosage was maintained. The phenothiazines were ordered for the patients in the usual manner and requisitioned from the hospital pharmacy, while the study drug (benztropine methanesulfonate or placebo) was obtained from the Nursing Office.

The study drug was supplied in bottles containing 31 doubly scored tablets of 2 mg. each. At least weekly, each patient was neurologically evaluated by the investigators, and the presence of side effects and their degree of severity were recorded on the basis of: 0 not present, 1 plus doubtful, 2 plus mild, 3 plus moderate, and 4 plus marked. In addition to the weekly neurological evaluation, the patient's ward physician would chart any side effects observed in his routine patient evaluation. If side effects occurred between evaluation periods the investigators were contacted and the necessary treatment instituted. If the patient's condition necessitated immediate treatment, he was then removed from the study. The study terminated at the end of 31 days; however, patients could be removed at any time prior to the specified time should their clinical condition warrant such action. A patient could be readmitted to the study after a 72 hour period of being off antiparkinsonian medication and he was then considered as a new member of the group. Those side effects whose severity was graded as 2 plus mild, 3 plus moderate, and 4 plus marked were recorded for the final tabulation.

The 83 patients (45 males and 38 females) between the ages of 19 and 63 (mean age 35.15 years) were admitted to the study for periods between three and 31 days (mean 24.25 days). The patients were randomly assigned to either the benztropine methanesulfonate or the placebo group, with 42 patients in the benztropine methanesulfonate group and 41 patients receiving placebo.

Results and Discussion

A total of 14 patients (16.84 per cent) exhibited some manifestations of extrapyramidal symptoms; of these, 13 patients (31.54 per cent) were in the group receiving placebo, and one patient in the benztropine methanesulfonate group (2.38 per cent). The differences between the group percentages are statistically significant beyond the 0.01 level. The single patient in the benztropine methanesulfonate group in whom extrapyramidal symptoms developed was a legal case and there is strong evidence to suggest that these symptoms were feigned by the patient for the purposes of malingering. Thus, it appears that benztropine methanesulfonate is an effective prophylactic agent in preventing the occurrence of extrapyramidal symptoms for patients on phenothiazine therapy.

The following types of extrapyramidal reactions were observed: In the nine patients with parkinsonism the manifestations occurring most often were disturbances of gait, rigidity, tremor, and sialorrhea. Akathisia was noted in two patients and combinations of parkinsonism and akathisia in three patients. None of the patients displayed any dystonic reactions, although these reactions are reported in the literature.

The mean age of the patients experiencing side effects was 31.08 years as contrasted to a mean age of 32.96 years in those patients not experiencing side effects. The differences are not statistically significant. The mean number of days on medication prior to onset of symptoms was 11.3 with a range of four to 26 days.

The literature suggests that the piperazine phenothiazines are more conducive of side effects than the nonpiperazine phenothiazines; however, the present study was not designed to investigate such differences. Side effects were noted in patients using piperazine and nonpiperazine compounds.

The development of extrapyramidal symptoms from phenothiazine compounds is an established fact; the mechanism as yet remains largely unknown. In attempting to make comparisons from the present study to the available literature, it is

readily apparent that factors such as drug dosage, time on drugs, specific drugs used, and patient status, acute or chronic, differ widely from one study to another. Consequently, even the prevalence of the various types of side effects remains uncertain [1-3,10] and variable from one investigator to another. While we found 64.19 per cent of the reactions to be of the parkinsonian type, Goldman[10] reported 35 per cent, and Ayd[2,3] reported 18 per cent when comparing the same phenothiazines. At the present time it is impossible to ascertain what specific factor or factors are responsible for these differences.

Our concern in preventing extrapyramidal symptoms by prophylactic use of antiparkinsonian medication rather than amelioration after such reactions occur is based upon two considerations of major importance. In current clinical practice it is accepted procedure for the psychiatrist to reduce the phenothiazine dosage when extrapyramidal symptoms occur, or when administration of antiparkinsonian medication following such symptoms fails to control the side effects. Such procedure, however, may deprive the patients of the maximal therapeutic effects to be derived from the phenothiazines. Furthermore, recent work by Boardman[4] indicates that more rapid clinical improvement occurs when extrapyramidal symptoms are prevented.

Our second consideration, however, is an even more cogent one, and in our estimation presents the major consideration for prevention rather than treatment of such side effects. The underlying assumptions in treating extrapyramidal symptoms after they occur have been twofold: that these symptoms are easily recognizable to the clinician, and secondly, that they are readily reversible.[5]

Many of the manifestations of the extrapyramidal side effects are insidious in their onset and subtle in their symptomatology. As an example, akathisia rarely presents itself as a well defined clinical picture. The patient generally complains about being restless, unable to sit in one place very long, and of being nervous and jittery. Such complaints, however, can be indicative of both akathisia and anxiety. The patient may be receiving either too much drug which results in akathisia or not enough drug to control the anxiety. The problem is often extremely difficult to assess, and the physician's decision to increase or decrease the phenothiazine medication is of vital importance to the patient's progress.

The often made assumption that side effects develop only after a patient has been on high dosages of the phenothiazines for long periods of time may also be erroneous. The results of the present study indicate that the patients in whom side effects developed were receiving a phenothiazine medication in the usual accepted dose range and that the mean number of days prior to the appearance of extrapyramidal symptoms was only 11.57 days. Freedman[9] studied the occurrence of cases of "low dose akathisia" and concluded, "Low dose akathisia results from individual specific sensitivity to a specific molecular configuration. There is a population with a low threshold." It appears that the two major considerations in the development of akathisia are (1) an individual susceptibility and (2) the chemical structure of the phenothiazine.

The second major consideration for a prophylactic approach to side effects is the recent evidence[8] indicating that the side effects of the phenothiazines may be irreversible. The majority of patients in whom such irreversible side effects have developed have been receiving the drugs for long periods of time. The fact that irreversibility does occur necessitates a more careful consideration of this problem, since our present state of knowledge does not permit beforehand determination of which patients will experience side effects and on what dosage the irreversible process begins. Consequently, it is our contention that prevention rather than treatment of extrapyramidal side effects is of the utmost importance at this time and should seriously be considered by the physician when he is planning the treatment of his patients.

As far as benztropine methanesulfonate itself is concerned, the side effects attributable to its use are minimal and are mild. Approximately 20 per cent of the patients in the current study complained of some dryness of the mouth or some blurring of the vision. Although we did not change the dosage, the reduction of this drug from 2 mg. daily to 1 mg. daily would be useful to investigate in order to determine if this would reduce the effects mentioned. Our experience with benztropine methanesulfonate has been generally duplicated, and in one study over 2,000 patients received this antiparkinsonian medication with no side effects except for the minor ones already mentioned.[10]

The treatment of the mentally ill with psychopharmacological agents still remains a challenge. We are still seeking the drug which will produce

the maximum therapeutic effect with the minimal number of undesirable features. Until this search is resolved, we believe that the concurrent use of antiparkinsonian and phenothiazine medication offers the acutely disturbed, institutionalized patient the benefit of receiving the maximum therapeutic effects from phenothiazines with a minimal chance of the emergence of undesirable side effects.

Summary

A study was undertaken to evaluate the prevention of neurological side effects by use of antiparkinsonian medication (benztropine methanesulfonate) with phenothiazines in acutely disturbed patients in an intensive treatment facility. Eighty-three patients were studied as to the development and degree of severity of neurological side effects; 42 patients received benztropine methanesulfonate and 41 received the placebo. Extrapyramidal side effects were noted in 14 patients; 13 of these reactions occurred in patients receiving placebo and only one in those patients receiving the benztropine methanesulfonate. The severity of the side effects and also the category of extrapyramidal reactions are noted. The mean number of days all patients were on the study was 24.57 while those patients in whom side effects developed were on phenothiazines for a mean of 11.57 days prior to symptoms.

The comparison of the dosage of the drug received by the patients who experienced neurological side effect and those who did not was not statistically significant. The only side effects which could be attributed to benztropine methanesulfonate were dryness of the mouth and some slight visual blurring. The low incidence of any major side effects of this drug has been well documented. The investigators think that the concurrent use of antiparkinsonian medication with phenothiazines offers the acutely disturbed patient being treated in an intensive treatment facility the opportunity to receive the maximal therapeutic benefit from the psychopharmacological drug while minimizing the occurrence of extrapyramidal side effects.

The authors are indebted to Dr. Franklyn Arnhoff, Research Associate Professor of Psychiatry, University of Miami School of Medicine, for his assistance in this study.

Benztropine Methanesulfonate (Cogentin) and placebo were supplied by Merck Sharp & Dohme, West Point, Pa.

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Acute Glomerulonephritis in Children

A Review of Thirty-Eight Cases

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In the three years ending Dec. 31, 1961, 38 children with acute glomerulonephritis were admitted to the wards of the Duval Medical Center. This report presents an analysis of the clinical features and emphasizes the role of impetigo as the precipitating factor in a large number of cases in this institution.

Twenty-one of these children have been followed a minimum of six months from the onset of the illness. In 17, the follow-up period has been one to three years. Twenty-six of the patients were Negroes and 12 white. This is a somewhat lower incidence than the 3 to 1 ratio of Negro to white children admitted to the service.

From the Pediatric Service, Duval Medical Center, Jacksonville.

There was a predominance of cases in the younger groups (fig. 1). Although the disease is seen the year around, the majority of cases occurred in late summer and early fall (fig. 2).

This seasonal distribution is probably the result of the strikingly high incidence of cases in which a skin infection preceded the development of acute glomerulonephritis. Sixty-one per cent of our patients on admission had impetigo in various stages of activity. The lesions were crusted or ulcerated and most numerous on the legs. In some cases they were present on the arms, trunk and face. In 14 of the 18 skin lesions cultured, beta hemolytic streptococci were isolated. Coagulase-positive staphylococci were also recovered in five patients. Throat cultures were obtained on

36 of the 38 patients, and beta hemolytic streptococci were recovered from only five. Of the 14 with beta hemolytic streptococci in skin lesions, only three had these organisms in the throat.

In four instances there was a history of acute glomerulonephritis in more than one member of the family. In one family of five children, two were admitted within the same month with impetigo and acute glomerulonephritis. A sibling had been admitted with the same train of events eight months previously. In a second family with 10 children, two had the onset of the disease at approximately the same time, the illness following acute pharyngitis. In two other families, each with eight children, two were affected simultaneously with the disease following impetigo and a third sibling had had acute glomerulonephritis 15 years previously.

Seven children in the series had received antimicrobial therapy prior to admission. Five had received daily injections of penicillin for one to five days and two had received tetracycline.

It is the child's edema which most often prompts the parents to seek medical attention, and in our series, facial edema was the most common presenting complaint. Most of the patients had been sick for several days before being brought to the hospital. In six instances, the child had been seen previously by a physician within four days of admission and the nature of the illness was not recognized. A change in color of the urine was reported by the parents in only one case.

All of the patients showed edema on physical examination at the time of admission. In some cases this was merely a slight puffiness of the face. That the edema may be appreciable can be noted from the subsequent significant loss in weight accompanying diuresis (fig. 3). The combination of impetigo and edema has sensitized us to a diagnosis of acute glomerulonephritis. Most of the patients had had skin lesions for two to three months before admission. One half of the patients had elevation of temperature above 100 F. on admission. The fever was not related to the type of preceding infection and declined to normal within 24 hours in most cases.

A diastolic pressure of 90 mm. of mercury, or above, was recorded in 76 per cent, and all were normotensive at the time of discharge. There was one death in this series.

Roentgenographic evidence of pulmonary congestion was present in 61 per cent, and changes were often extensive even in the absence of any



Figure 1.

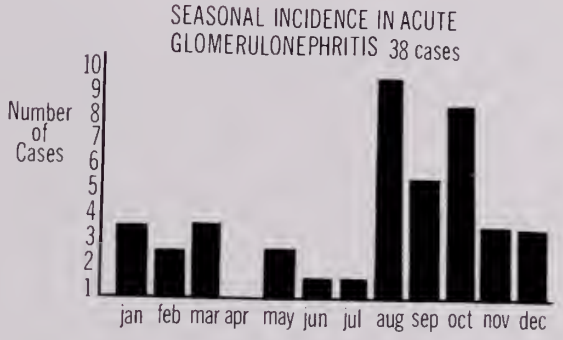


Figure 2.

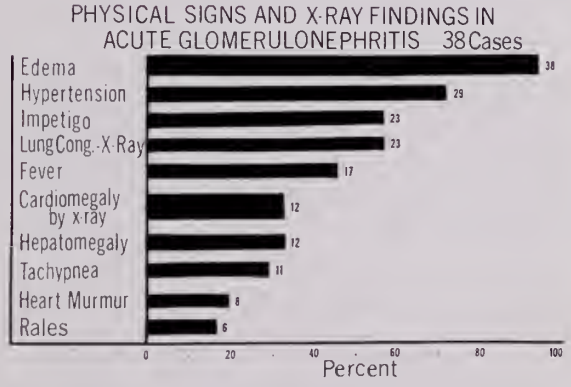


Figure 3.

pulmonary symptoms. The presence of rales was an infrequent finding. Tachypnea was a more frequent finding, being present in 11. Twelve had an increase in heart size by roentgenogram. Grade I to III systolic murmurs were heard in eight patients.

Occasionally a patient admitted with tachypnea, roentgenographic evidence of pulmonary congestion, edema and normal blood pressure may offer considerable diagnostic difficulty. This is



Figure 4.

especially true if the initial urine examination shows no hematuria. We have had such patients admitted in whom the diagnosis became apparent only after repeated urinalysis revealed microscopic hematuria.

In our series, cardiac enlargement was seen as frequently in patients with normal blood pressure as in those with hypertension. Roentgenographic evidence of pulmonary congestion was seen in eight patients with normal blood pressure. Electrocardiograms were recorded on 20 patients at some time during the illness, eight of which showed some variation from the usual pattern for their age. These were reported as nonspecific changes in the T waves.

Laboratory. — The urinary findings in most were consistent with the typical findings of the disease, and included slight to moderate proteinuria, hematuria, and granular casts in approximately one third. Of interest was the presence of over 20 leukocytes/hpf in the urine sediment of eight patients. Table 1 shows the variation of the number of erythrocytes seen in the urine sediment. These values represent the maximum number seen in repeated examinations of the urine sediment of each patient. In a few patients, repeated urinalysis failed to reveal significant hematuria. These were patients whose disease was, in all other respects, characteristic of acute glomerulonephritis. A recent report documents similar findings in two patients in whom renal biopsy confirmed the diagnosis of acute glomerulonephritis.[1]

Most of our patients showed a definite anemia, with two thirds having hematocrit values of less than 30 per cent. In 21, hematocrit values were obtained at the time the patient was edema-free as well as on admission. The change in hematocrit values and the loss in weight of each of these patients are shown in figure 4. Fifteen patients showed a rise in hematocrit value, three showed no change, and three showed a decrease. The anemia of acute glomerulonephritis has been attributed to hypervolemia with hemodilution. Our findings suggest that other factors may also be contributory.

Somewhat less than one third of the patients had normal blood urea nitrogen values on admission (table 2), and the remainder had mild to moderate nitrogen retention. The hypoalbuminemia occurring in patients with acute glomerulonephritis is well illustrated in table 3. Very few of the patients had serum albumin values within the normal range. In contrast, the serum globulin values were usually elevated (table 4) Serum electrophoresis was performed in 10 cases and the findings here confirm the presence of hypoalbuminemia and elevation of all the globulin fractions. Serum cholesterol determinations were made on 22 patients, and in four of these the cholesterol was between 250 and 350 mg. per hundred cubic centimeters. Repeat determinations on these patients gave normal values.

Antistreptolysin O titers, determined in 27 of the patients, were below 150 Todd units in eight, between 150 and 250 in 14, and greater than 250 in five. Since repeat determinations were not made in most instances, it is apparent that a change in titer was missed and that these figures do not give a true representation of expected figures. The erythrocyte sedimentation rate, determined in all patients, was 20 mm. per hour or above in 33. This is of interest, since some clinicians have used the sedimentation rate as an index of the activity of the disease process.

Management

All patients were kept at bed rest until they were asymptomatic, normotensive and had lost the edema. They were given a low salt diet and penicillin therapy. Loss of the edema was best indicated by stabilization of weight following the initial loss in weight. Microscopic hematuria was not considered a contraindication to activity, and a majority of the patients, 22, still had microscopic hematuria at the time of discharge.

Twenty-eight patients received antihypertensive therapy in the form of intramuscular injections of reserpine 0.07 mg./Kg. and hydralazine hydrochloride (Apresoline) 0.1 mg./Kg. in combination. These drugs were given when the diastolic blood pressure was over 90 mm. of mercury.

Twelve patients required only one injection of the drugs; seven required 10 or more doses of the drugs. The remainder received from two to seven injections. Eight patients were treated with digitalis. Indication for its use was a combination of pulmonary congestion as noted in the roentgenogram, enlargement of the liver, cardiac enlargement and gallop rhythm. All patients who were digitalized did not show all of these signs. Digitalization was continued until all signs of cardiac failure had disappeared. The average hospital stay of the patients was 11 days. At the time of discharge, they were ambulatory and were allowed to go back to school.

The one death in the series was that of a two and one-half year old Negro boy whose acute glomerulonephritis followed impetigo. His death was attributable to plumonary edema.

Discussion

Several features noted in this series warrant further comment. Most texts give little cognizance to the role of impetigo in the pathogenesis of glomerulonephritis. This lesion, often considered of staphylococcal origin, indeed begins as a superficial hemolytic streptococcal infection, but often becomes secondarily invaded by the staphylococcus. Its streptococcal nature is surely apparent when a series such as this is studied. Futcher[2] directed attention to the role of impetigo in the genesis of acute glomerulonephritis, reporting two cases for Johns Hopkins Hospital in 1940. Other reports have confirmed this. One can anticipate that careful study of the urine in patients with impetigo might uncover many cases of glomerulonephritis.

This series emphasizes the point that heart failure is not directly related to the degree of hypertension, but rather is a function of retention of salt and water with subsequent overloading of the circulation.[3] The role of specific myocardial lesions in this train of events is debatable.

That a single negative urine examination does not rule out acute glomerulonephritis is apparent. Frequent urinalysis may be required to detect the often evanescent abnormalities of the urine sediment.

Table 1. — Erythrocytes in Urine Sediment In Acute Glomerulonephritis

RBC/HPF	No. Cases
0	1
0 - 5	2
5 - 20	9
> 20	26
Total	38

Table 2. — Blood Urea Nitrogen in Acute Glomerulonephritis

Mg./100 cc.	No. Cases
15 or less	11
16 - 20	4
21 - 30	10
31 - 40	6
41 - 50	5
Over 50	2
Total	38

Table 3. — Serum Albumin in Acute Glomerulonephritis

Gm./100 cc.	No. Cases
< 2.5	7
2.5 - 3.0	12
3.1 - 3.5	8
3.6 - 4.5	1
> 4.5	1
Total	29

Table 4. — Serum Globulin in Acute Glomerulonephritis

Gm./100 cc.	No. Cases
< 2	0
2.1 - 2.5	1
2.6 - 3.0	4
3.1 - 3.5	8
> 3.6	16
Total	29

Finally, the good prognosis of acute glomerulonephritis is obvious. Whether this disease goes into a chronic phase with the ultimate pattern of nephrosis and then hypertension and uremia is questioned by some. Our period of follow-up cannot add evidence in either direction.

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Special Article

Research at University of Florida College of Medicine
Department of Pathology

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The Department of Pathology at the University of Florida College of Medicine was organized in 1956 in accordance with the time-honored fact and philosophy that the field of pathology was founded through research into the fundamental nature of disease and that research will always be a primary obligation of the pathologist. Today, as always, this approach includes the development and application of new methods in the study of disease from any perspective that offers promise of new knowledge.

The department was first housed in a single office and laboratory in a temporary building on the University of Florida campus. As soon as the new Medical Sciences Building was ready for occupancy, research programs were instituted under the direction of the Chairman of the department, Joshua L. Edwards, with three other members of the faculty, Victor M. Arean, Charles F. Crampton, and C. Ian Hood.

Inception of Research Programs

Support for research activities was immediately forthcoming in the form of four research grants from the United States Public Health Service enabling the beginning of studies concerned with the pathogenesis of certain infectious diseases, studies on the intracellular events in antibody formation, continuation of investigations on the metabolism of antigens and further development of new methods in the fractionation of nucleic acids and histones of normal and pathologic tissues.

The first projects were undertaken in the laboratory of Dr. Edwards, a graduate of the University of Florida and Tulane School of Medicine, whose postdoctoral training in pathology was in laboratories of pathology of Touro Infirmary, New Orleans, the New England Deaconess Hospital in Boston, and Harvard University. He joined the faculty of Duke University School of Medicine and later was on the scientific staff of the Rockefeller Institute for Medical Research.

Early investigations included testing of the hypothesis that focal inflammatory lesions of the heart and brain responsible for fatalities in acute trichinosis occur primarily as a result of a combination of antibodies and antigens deposited by trichinella larvae in their migration through tissues. A number of experiments including the production of these lesions even in animals lacking a capacity to synthesize antibodies refuted the validity of this hypothesis and led to more detailed knowledge of the life cycle of this parasite.

Concurrently, studies were undertaken to determine the rate of new cell proliferation in antibody-forming tissues at different times following the injection of antigens with special attention to the distribution of the newly proliferating cells in relation to the cellular distribution of antigen. It was clearly shown that cells in the immediate neighborhood of antigen-containing cells were the first to begin the explosive burst of cell division that leads to antibody formation. Furthermore, a definite spatial pattern in cell proliferation follows sequentially in lymph nodes leading to the appearance of plasma cells that participate in mitotic activity and ultimately antibody formation.

Closely related studies on the metabolism of antigens were undertaken by Dr. Crampton, who received the B.S. and Ph.D degrees in science and biochemistry at the University of Indiana, and completed four years of postdoctoral research at Columbia University and the Rockefeller Institute before joining this department. He received

Professor and Head, Department of Pathology.

the first John and Mary R. Markle scholarship awarded to a member of this faculty at this institution. Here he continued his earlier studies on the isolation and fractionation of histones and nucleic acids from normal and abnormal cell tissues developing methods that have been widely adopted in recent years for other studies of these compounds. In his investigation on the rates of turnover of nucleoproteins, he found that certain specific proteins of the cell nucleus, histones, paralleled in their rate of turnover that of the desoxyribonucleic acids with which they were associated. It was also through these and earlier studies of Dr. Crampton that the chemical basis of the heterogeneity of these biologically important moieties was first demonstrated. Dr. Crampton also participated in an investigation concerned with the metabolism and distribution of antigens in tissues that led to his formulation of a theory of antibody formation. Dr. Crampton's promising career ended with his death in 1960.

Dr. Arean received his clinical training in the University of Madrid and his specialty training in pathology in this country. Formerly associated with Tulane University, the Ochsner Clinic and the University of Puerto Rico, he joined this faculty in 1956. Studies on leptospirosis and ascariasis were begun applying a combination of biochemical, immunologic and histologic methods to several problems concerned in the pathogenesis of these infections.

Dr. Hood received his clinical training at the University of Liverpool and trained in pathology at Cornell University Medical College. His research activities have been in collaboration with several members of the faculty and include studies of the pathogenesis of certain specific infectious diseases and studies of the renal lesions of hypertension.

Extension and Development of New Research Programs

Tritium autoradiography, employed by Dr. Edwards in the study of new cell proliferation during antibody formation, was later applied to other fundamental questions concerning cell renewal with the finding of much more precise values for the rates of turnover of more than 30 different cell types in mammals and evidence concerning the validity of the stem cell theory of cell growth. The studies have led to a more precise formulation of the kinetics of growth of several types of normal and neoplastic cells and demonstrate that a pattern of spatial synchrony



The instrument shown here in operation is a scanning and integrating microspectrophotometer used for precise measurements of specific substances in the interior of individual cells.

exists among populations of cells that is determined by factors other than their genetic (clonal) relationships. More recently, studies on the role played by the thymus gland in the population of other lymphoid tissues have employed chromosome markers to measure the extent and rate of migration of cells in early mammalian development. Other investigations in this laboratory are focused on the mechanisms of cell and tissue growth especially in respect to the binucleation and polyploidy of cells as related to their capacity for rapid regeneration.

The addition of Dr. Catherine Crandall to Dr. Arean's research group in infectious disease led to studies that included some of the first attempted in this department with electron microscopy. Extension of activities in this laboratory also involved an investigation on the vulnerability of various stages of Ascaris larvae to a variety of physical and chemical agents and successful efforts in the in vitro cultivation of these parasites through portions of their life cycles. The capacity of the larvae to produce lesions was correlated with their cytochemical composition and behavior and the stages of their immunogenic development.

A new area of research was added to the departmental activities with the appointment of Dr. Douglas Shanklin, whose undergraduate and medical training was obtained at the State University of New York at Syracuse. Earlier in his career he was, for a time, a research associate of Dr. Philip B. Armstrong, working on some problems involving membrane transport in marine organisms. At Duke University and the State University of New York at Syracuse, Dr. Shanklin be-

gan preliminary studies of hyaline membrane disease in human beings. Dr. Shanklin's area of research is concerned with the problem of adaptation of the newborn in the perinatal period and related problems in cardiopulmonary physiology. Accomplishments to date include a description and new evaluation of the rate of autolysis of the fetus in utero, new observations concerning the effect of fixatives on soluble proteins in tissues and the development of surgical techniques on the fetus in utero including nephrectomy and vagotomy of the rabbit fetus. Several experimental models have been developed for the production of hyaline membrane disease in a variety of experimental animals and current work involves a systematic evaluation of the factors that may be important in the pathology and pathogenesis of this disease of the human being. Some of these include histamine concentrations, hypoxia, hyperoxia, vagal function and ascorbic acid and estrogen levels. Evaluation of these factors involves studies on the transport of colloidal substances across membranes and factors affecting the permeability barriers.

Momentous developments in recent years of cytologic methods, including cytochemistry, cytospectrophotometry, electron microscopy, and other highly specialized types of microscopy, make it essential to bring these tools to bear on problems in experimental and diagnostic pathology. The research potential of the department was increased along these lines by the addition to our faculty of Dr. Ronald Cowden, a developmental biologist who received his undergraduate training at Louisiana State University and his graduate training in biology at the University of Vienna. Since his formal training, he has acquired a vast experience with research methods in cytology and cell biology. Research programs in comparative pathology and cell biology have thus become active programs in this department. Dr. Cowden and his associates have provided fresh insight into the problem of oocyte development concerning factors determining the rate and potential of differentiation of different types of ova. Quantitative studies of the nucleic acid and protein components of various types of hematopoietic and connective tissue cells during their normal differentiation and investigation of intracellular events during regeneration of various types of tissues at different levels of the phylogenetic scale are underway.

Research projects in other areas were activated with the addition to the faculty of Dr. John B. Henry, a graduate of the University of Rochester whose formal training in internal medicine and pathology was obtained at Washington University in St. Louis, Columbia University College of Physicians and Surgeons and the New England Deaconess Hospital in Boston. Through his direction of the clinical laboratories, clinical investigations have resulted in the development of what is a now widely used immunological test for pregnancy, the finding of a hitherto undiscovered rare blood group and semiautomated systems for enzyme measurements. His primary research has involved a systematic study of a number of neoplasms, hyperplastic lesions and their normal tissue counterparts in respect to the activities of selected enzymes concerned with glycolysis, the citric acid cycle, and the hexosemonophosphate shunt. The pattern of quantitative variations in these enzyme activities indicates that there is a gradual shift of metabolic activity to increased use of the hexosemonophosphate shunt that is associated with loss of differentiation as measured by morphologic criteria.

The fine structure of the nervous system became yet another field of research in this department with the addition to our faculty of a neuropathologist who is also an accomplished electron microscopist. Dr. George Collins, a graduate of the University of Vermont, received his formal training in neuropathology at the Massachusetts General Hospital. His primary research project is a study of the effect of thiamine deficiency upon the central and peripheral nervous systems. The first objective was to determine the structural element responsible for the selective degeneration found in the central and peripheral nervous systems. Further efforts will attempt to delineate the ultrastructural basis for the vulnerability and cellular mechanics involved. The role played by alcohol and other toxic factors such as methyl glyoxal in this process is also under study. In carrying out this project important improvements of methods of fixation of brain for electron microscopy have been developed.

Dr. Ray Hackett, also of the University of Vermont, came to this department from the department of pathology of Massachusetts Memorial Hospital. He has undertaken a study of the cytodifferentiation and behavior of mast cells. Although these cells carry well defined biologically active compounds such as histamine, serotonin and heparin, their role in the inflammatory re-

sponse and coagulation phenomena is still poorly understood. Results so far indicate that degranulation of these cells is not necessarily associated with cell death and the "regeneration" of mast cells consists largely of resynthesis of granules.

A definite morphologic pattern of mast cell development correlates well with chemical changes in the granules. Currently, isolated populations of mast cells are being cultured in millipore filter chambers in vivo in order better to define the kinetics of the cell cycle.

Research Facilities and Research Training

Over the period of years since the department was organized, there has been a steady growth in breadth and depth of research programs that involve, among other things, the acquisition of an impressive armamentarium of research equipment and techniques. Various agencies including the Florida Crippled Children's Commission, the Florida Division of the American Cancer Society, and the United States Public Health Service have made this possible by continuous support of these research efforts.

With interference, polarization, ultraviolet, and electron microscopy, x-ray-radiography, and visible scanning integrating microspectrophotometry methods available, there are few if any departments of pathology more diversely equipped for quantitative cytologic research.

Public Health Service grants for training predoctoral and postdoctoral fellows in research now support eight such trainees who are carrying out research projects under supervision of members of this faculty. The objective of this research training program is to train pathologists for research in academic careers in addition to their conventional training in anatomic and clinical pathology.

Relationship of Research to Teaching and Service Activities

A department of pathology in any medical school must develop active organized programs in three areas, namely, graduate and undergraduate teaching, and services rendered in patient care, as well as research. The effectiveness of these different types of programs is dependent in large part upon the contribution each makes to the others. For example, the continuous activities centered around detailed studies of pathologic specimens from the autopsy and surgical pathology services not only serve the purpose of good patient care but also are the heart of our teaching programs. These studies do not end merely in student demonstrations and reports of pathological findings. Information so obtained may suggest crucial questions or new hypotheses about the pathogenesis of disease and furnish important leads that can be explored further in the research laboratory. An equally direct relation exists between the teaching and research programs. From the outset of the development of this department of pathology, methods and results successfully applied in experimental investigations, when they offer an opportunity for presenting material in a new light or from a different perspective, have been adopted for use in the undergraduate teaching laboratory. The practice has resulted in an orientation course in general pathology that is widely recognized as highly effective and unique in many respects.

President's Page

Charity

Though I speak with the tongues of men and of angels, and have not charity, I am become as sounding brass, or a tinkling cymbal. 1 Corinthians 13:1

The Christmas season is upon us. It is natural that all thoughts turn to gifts, charity and love, but in our profession Charity is, or should be, a part of our daily lives. It is a fact that, in our day, the word "charity" has been revised out of First Corinthians and the word "love" substituted. Apparently, the word "charity" was coined to translate the Greek word "agape" which described the love of God relating only to one's need, not to his goodness or badness. It was love without regard for return or reward. It is unfortunate that a more general and less meaningful term has been substituted, but it had to be displaced in this age of increasing socialism which does not consider need.

Contrary to the more calloused approach of our day, let us not forget that the physicians of this nation contribute annually approximately five thousand dollars each in services donated to our fellow men. This totals $657,535,000, more than the reported contributions to all United Funds. Physicians by their donations of time assure the success of many of the good works reported by these funds, yet rarely, if ever, have we seen credit recorded for such services, although they may be quick to remind us of our failure to meet assigned monetary donations. Other voluntary health agencies vary in their recognition of physicians' time. Perhaps it is our fault in that we have failed to "sound our brass" because many of us accept the original definition of "charity" and give it without expectation of reward.

"Make your minutes count and the harvest of your days will be assured. Remember that time is money," said Benjamin Franklin. In no field is this statement more accurate than in medicine because knowledge and time are our livelihood, and when either wanes, our lot is imperiled.

As the federal government assumes more responsibility for the health care of our people, it is easy to be lulled into selling our birthright for a mess of pottage. The New Materia Medica poll of 1961 revealed Florida general practitioners were leading the nation in giving medical services with $4,762 each: Florida specialists were second among specialists with $5,078. These are commendable figures, but we must not rest on our laurels. We should be familiar with our House of Delegates recommendations on charitable services. County societies should attempt to see that their members recognize reasonable standards regarding those who may be eligible. It must be understood that we should be guided by the principle of the Golden Rule in attending the needy.

Under our present system we are not forced to take any patient, charity or otherwise, but the obligation is ours to take those who need us. Once we accept a patient, it is our duty to render the best services possible at a price the patient can afford to pay. If he can afford nothing, charge nothing. If he can afford a little, it helps his dignity to let him pay a little. If we are morally honest in applying our charges, our *responsible* public will be satisfied, and there will be no strong support for government medicine.

It is extremely difficult to approach this subject in an honest, enlightened way with satisfaction to everyone concerned. We must remember that some doctors are not morally honest, and some patients are not honest: some doctors do no charity work, and some patients cheat. Fortunately, these are a small minority. Generally speaking, one can never satisfy a welfare stater or a socializer regardless of what is given. As long as we keep our own house in order and remember the word "charity"—giving without receiving according to need, we can keep our heads high, speak with the tongues of men and deal with government and other groups with a clear conscience.

MERRY CHRISTMAS!

Sam Day



Editorials

The Unknown Child of Bethlehem

"Unto you is born this day in the city of David a Saviour, which is Christ the Lord." Luke 2:11

"In the midst of the reign of Augustus, when profound peace prevailed throughout the civilized world, Jesus was born in Bethlehem of Judea. The event was unheralded in Rome." So wrote P. V. Myers in "A History of Rome." The birth of Jesus was not only unheralded; it was not even whispered in Rome. Emperor Caesar Augustus had little thought for what happened in the insignificant outpost of Judea in the midst of a despised subject people.

Who would think that the great Emperor could be disturbed by the birth of a child born in poverty and the obscurity of questionable parentage? It would be the joke of Rome! The Emperor had more important things to occupy his time. After all, one must be realistic; how could the birth of such a child in any way affect the history of mankind? It was beyond any reasonable mind to conceive that the mighty Empire overwhich he ruled would ever lower its proud eagles in deference to an execution cross on which that "unknown child of Bethlehem" was to die.

The parents of this child were ordered, by an edict of Augustus Caesar: "For there went out a decree from Caesar Augustus that all the world should be taxed." And so the peasants from Galilee came to enroll. It was this order of Augustus that sent Joseph and Mary out on the rocky road from Nazareth to Bethlehem. Here again is the proud boast of Rome: "all the world—orbis terarum," the whole of the earth was under his dominion. The rich merchant princes who gathered at Bethlehem were busy feasting in the Inn. The Roman garrison was busy enrolling the people as they arrived in the city. No one had time "for a woman with child." No place for them in the Inn, only a stable for a shelter, where the unknown child could be born that night in Bethlehem. These are facts. But there are other unusual and fanciful events surrounding the birth of the unknown child. Angels were reported singing over the hills of Bethlehem as shepherds watched their flocks. A star appeared in the heavens. Far off in the mystic East a little group of astrologers were strangely attracted by that star. These religious seekers believed that the star was a portent of something great, even the birth of a King. So according to the story they set out on the long quest to find a new-born King.

Naturally they went to the palace of the king to find out what was happening. But as is often true, the government knew not as much as those who came seeking. Out of an ancient book they read: "In Bethlehem of Judea, for out of thee shall come a governor who shall rule my people Israel." So to Bethlehem they came.

What changes the centuries have wrought. The tourist travels far to see the place where Jesus was born, while all that remains of the glory that was Rome is but a few crumbling columns in the cat-infested forum of Rome. Who knows or cares what happened to Caesar Augustus? But the "Unknown Babe of Bethlehem," unknown to the great of that day, not wanted at the Inn in Bethlehem, born in a stable, hated and hunted by Herod the King, is still remembered and loved by millions of men and women of the world. And now it is Christmas and all remember Him.

But human nature changes so slowly. After two thousand years He is still unknown. It is symbolic that we removed "Christ" from Christmas. The world is so busy and so efficient that we must shorten even Christmas. We call it Xmas. Of course we know X stands for Christ, but X also is the symbol for an unknown quantity, a term used to designate a person whose true name is unknown. X may be more than a symbol; it may be a parable of our time.

It staggers the imagination when we stop to remember what this unknown Babe of Bethlehem has achieved. He divided time into "B.C." and "A.D." (before and after His birth). When He came, there was not one hospital, nor one orphanage, nor any place of refuge for the troubled and outcast in the Roman Empire. How changed it is

today. And all primarily because a Babe unknown was born in Bethlehem. It is good to get acquainted with this Christ and put Him back into Christmas, for in Him and His way are found the truth and the life.

"Are you willing to stoop down and consider the needs of little children, to remember the weakness and loneliness of people who are growing old, to bear in mind the things that other people have to bear on their hearts, to make a garden for your friendly feelings with the gate open—are you willing to do these things even for a day? Then you can keep Christmas!

ALBERT J. KISSLING, D.D.
RIVERSIDE PRESBYTERIAN CHURCH
JACKSONVILLE

Editor's Note: This is the fourth in a series of guest editorials appropriate to the season by leading ministers and rabbis published upon solicitation in the hope that physicians will find these messages a source of guidance and inspiration.

Post Mortem

Twenty-seven years ago, in his first novel, this writer proposed a system of prepaid medical care at a time when "health" and "insurance" were almost dirty words, if used together. The years since have seen doctor-sponsored Blue Shield and Blue Cross plans cover the nation, bringing a considerable measure of protection to the public against the costs of medical care. Yet the increasing excellence of that care has steadily increased its cost—notably in the hospital expense sector—until ordinary hospitalization policies often prove inadequate in cases of serious illness.

Through the years a parade of compulsory health insurance schemes under government control—the very danger that led the writer to devise the plan described in "That None Should Die"—has passed before the Congress, to be rejected so far, it is true, but by steadily decreasing pluralities. Recently the Medicare plan of the present Administration was passed by the Senate, but allowed to die in the House with surprisingly little objection, possibly because of its value as a campaign issue in an election year. But with the lopsided plurality registered for the Administration by voters in November, who can doubt that Medicare will again become an issue in 1966? Or that the tremendously increased power of an Administration committed to putting into law the welfare state provisions of the so-called Great Society will also be behind Medicare?

All of which makes it important to ask ourselves: Where do we go from here?

For various reasons, some valid, most not, the electorate appears to have repudiated the sort of individual independence and liberty for which medicine as a profession has always stood. More important, an honored profession which can only oppose so-called medical welfare plans which it knows to be economically and sociologically—to say nothing of morally—unsound is likely to end as a political "whipping boy." At some point in every military battle—and medicine will soon be engaged in a life or death battle for its survival as an independent profession—there comes a time when only a well directed attack, often against superior odds, can bring victory. And, if there was ever a time in the past thirty-odd years since the first Murray-Wagner-Dingell bill, when such an attack should be the order of the day, it is now. The problem is where and how.

Perhaps the greatest contribution of the late President Hoover to his country was his leadership of a commission that made a thorough study of our government and published a broad set of recommendations for its improvement and more efficient operation. True, not many of those recommendations have yet become law, but the study was made, the truth is a matter of record, and President Hoover's already giant stature was increased greatly because of it.

At a time when the whole problem of adequate medical care for all is sure to be attacked piecemeal by poorly thought out legislation, it would therefore seem very wise indeed for all sectors of the medical scene—doctors, dentists, hospitals, nurses, hospital insurance carriers, and others connected with medical care—to join in establishing a Hoover Commission, so to speak, for medicine. This commission should study impartially all aspects of medical care, from professional education to medical economics, and report its findings to the country. If persons of sufficient national prestige comprised such a commission, its findings would automatically carry great weight with the Congress, where the final battle against politically motivated health schemes must be fought. Whatever final legislation emerged—and it is short-sighted indeed to think that some law vitally concerning medicine will not be signed before the next session of the Congress ends—would be legislation proposed by those whose major interest is the best possible medical care for the most people instead of schemes largely designed for their vote-getting power.

The time for such a study is now—before some disastrous health plan finds its way to the statute books.

FRANK G. SLAUGHTER, M.D.
JACKSONVILLE

Editor's Note: This is the twelfth consecutive year The Journal has published a guest editorial in December by Dr. Slaughter, Florida's distinguished physician-author.

FMA Forty-Eight Years Ago

It was my good fortune during the first year of practice to be present and to participate modestly in the Forty-Third Annual Meeting of the Florida Medical Association, which was held at Arcadia, May 10-12, 1916.

The accompanying photograph of some 54 members, made just outside the auditorium, shows about 90% of those attending. How different it looks from one made today. Certainly there would be few if any hats, not many coats, and no stiff starched collars. A few white shoes and socks might appear.

Of the fifty-odd doctors named in the proceedings either as participants in the scientific program or the business activities, only four are still living.

The scientific program consisted of 24 papers, in three sessions, given and discussed by members only. There were five papers on diagnosis, five on surgery, one on ophthalmology and the remainder on general medicine. Each was actively discussed by two to five members. The absence of specialization drew all of us to the same program at the same time and the lack of formal entertainment gave us the opportunity of getting to know one another through "visiting" together in the hotel lobby and on the front porch.

The only social event was the annual banquet the last night. A striking feature was the complete absence of ladies or visitors. There were no scientific or commercial exhibits.

The report of the Secretary-Treasurer stated that there were 31 county societies, 621 members and total assets of $1,409.67.

A resolution was presented by the Woman's Club of Jacksonville requesting the Association to join with it in presenting to the Florida Legislature a bill prohibiting advertising by the local and state press of "various nostrums to be used for commercial purposes, and also remedies and treatments purporting to cure social diseases, and alleged maternity homes for unfortunate women." The matter was referred to the Committee on Legislature and Public Policy.

Illustrating the public interest in the consumption of alcohol, representatives of the Woman's Temperance Union requested the adoption of a resolution which concludes: —"The F.M.A. . . . hereby pledges its earnest efforts against the deadly foe to mind, body, and soul." The minutes read: "After considerable discussion" the resolution was referred to the Committee on Scientific Work.

Most of the impressions and memories of that 1916 meeting are as clear as though they occurred yesterday. The stimulus to continued interest has not lessened as our Association has grown from a membership then of 621 to 5,100. The annual meetings have changed in size and character and grown in efficiency and importance in the lives of its members as well as the general community.

The question arises: "If a meeting of the Association such as that one 48 years ago could mean so much to those present, by what yard stick can one measure the value to its members of an annual meeting today?"

EDWARD JELKS, M.D.
JACKSONVILLE



Association News

Regional Conference of State Medical Journals

Discussions of the contents of state medical journals, the appearance of the contents to the reader, the manner in which these factors should be paid for and the business aspects of publication attracted much attention at the Regional Conference of State Medical Journals held early in October at Baltimore.

The keynote address by Mr. William H. White, Executive Editor of Medical World News, following greetings from Dr. George H. Yeager of Baltimore, Editor of the Maryland State Medical Journal, emphasized the value of the local aspects of the state journal, its direct contact with the practicing physicians and the need for a dynamic editor and an editorial committee having wide and friendly contacts with their colleagues. He urged that careful attention be given to the contents of each issue; suggested that local science writers be used in providing short articles on important medical meetings, and pointed out that good material does not come to the journal staff which sits back and waits. Mr. White stated that the staff should study the successful medical publications and adapt their "tricks" for attracting readers, maintaining a careful cost consciousness, but at the same time whetting the readers' appetite.

In concurrent discussions, it was suggested that the journals pay particular attention to their covers, letting them reflect the manner in which the material inside the issue is presented. Other topics including billing problems, postal regulations, the material for a good medical journal, obtaining good articles and tactfully rejecting manuscripts of poor quality, editing and the regional printing of journals completed the day's program.

Next morning, again in concurrent sessions, there were discussions of the use of color to make the publication more attractive, ways to improve the quality of the journal and to make it more readable and the tax situation regarding the state association publications.

In the general session concluding the program, John L. Murphy of New York, Sales Director of the State Medical Journal Advertising Bureau, asked the staff of each journal to assist him in selling advertising for them. He requested the journals to distribute their own promotion material; notify the Bureau of plans for special issues or the publication of an article on the results of a specific drug; make a special selling effort among the district managers of prospective advertising firms in the event the district office is within the particular state; give special preference to firms advertising in the journal when exhibit space is assigned at meetings of the medical association; send copies of the journal to prospective advertisers and their agencies, and show definite indications of readership, such as letters, coupons and local advertising.

Mr. Murphy urged that, at all levels, most advertising promotion be of a personal nature and stated that he would hesitate to advise expenditure of revenue for a readership survey. He urged cooperation and assistance in his efforts to sell the state journals to national advertisers, and stated that of the 30 companies buying 90 per cent of medical advertising, only 15 are using state journals as media, and of the top 10 space buyers, only five are utilizing the state journals. If two more of the top five would use the state publications, most of them would be able to pay their own way this year, he said.

At the local level, it is important that the members of the Florida Medical Association be more aware of the firms using the official state journal. The Board of Governors has approved the request that a list of the advertisers be included in the official packets compiled for members of the House of Delegates at the Annual Meeting in April. It is necessary that the Delegates and each member of the Association express appreciation to these companies by word, letter, and when suitable, utilization of their products.

THAD MOSELEY, M.D.
EDITOR

Legislative Roundup The 88th Congress in Review

Adjourning on Saturday, October 3, the 88th Congress passed into history. By almost any measure, the 88th had a busy and eventful two year term. Approximately 20,000 bills had been introduced in the House or Senate. Of these, 850 affected medicine, medical care, or the public health. The American Medical Association presented its views on pending legislation on 25 occasions as well as providing 16 informational statements to various committees of the Congress. It took nearly 61,000 pages in the Congressional Record to record the 88th Congress' deliberations of the various proposals which came before it.

Some of the more major measures of medical interest which were enacted into law were: the Health Professions Educational Assistance Act which provides construction grants for the construction of teaching facilities and a student loan program; Maternal and Child Health and Mental Retardation Planning Amendments providing grants to help meet the cost of special projects, research, and other activities; Mental Retardation Facilities and Community Mental Health Centers Construction which authorizes grants for the construction of research and clinical facilities, and for community mental health centers; Clean Air Act expanding the federal government's role in air pollution control; Hospital and Medical Facilities Amendments which extended for five years the Hill-Burton hospital construction grant program and adding to it, grants for the modernization of existing facilities and for area-wide health facilities planning programs; and the Nurse Training Act authorizing grants for the construction and modernization of nursing schools, and establishing a loan fund for student nurses.

Several other bills of interest to medicine failed to gain approval of both houses of the Congress, and died with the adjournment of the 88th Congress. Included were: a water pollution control measure; reorganization of the U.S. Public Health Service; the creation of an "Office for Senior Citizens" in the Department of Health, Education, and Welfare; the King-Anderson medicare-tax proposal; chiropractic care for federal employees under the Federal Employees' Compensation Act; a psychotoxic drug control program; and a bill which would have exempted nonprofit blood banks from the antitrust laws.

COUNCIL ON LEGISLATIVE ACTIVITIES
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1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

SEARLE

Research in the Service of Medicine

Meetings

December

Second Annual Seminar in Cardiology, "Diagnostic Methods in Cardiology," December 3-6, Tampa General Hospital, Tampa.

Seminar in the Present Status of Amputation Surgery and Prosthetics, December 3-5, Americana Hotel, Bal Harbour, Fla.

January

Seminar on Infectious Diseases, January 9, Auditorium, Duval Medical Center, Jacksonville.

Gastroenterology Seminar, January 14-16, University of Florida College of Medicine, Gainesville.

Pediatric Seminar, "Current Concepts in Allergy and Clinical Immunology in Childhood," January 21-23, University of Florida College of Medicine, Gainesville.

"Respiration," Second Annual Postgraduate Seminar, January 22-25, Eden Roc Hotel, Miami Beach. Sponsored by University of Miami School of Medicine and University of Florida College of Medicine.

Seventh Annual Conference, County Medical Society Presidents and Secretaries, January 23-24, Robert Meyer Motel Hotel, Orlando.

"Selected Aspects of Congenital Heart Disease," Regional Meeting, American College of Cardiology, January 28-30, University of Florida College of Medicine, Gainesville.

Seventh Annual Cardiovascular Seminar, January 30-31, Port-O-Call, Tierra Verde, St. Petersburg.

February

Seminar in Psychiatry in Medicine, Department of Psychiatry, University of Miami School of Medicine, Jackson Memorial Hospital, begins February 10, continues each week.

Seminar on Surgery of the Hand, February 13, Auditorium, Duval Medical Center, Jacksonville.



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Colon and Rectal Surgery
Wiley Mitchell Sams, M.D., Miami, Fla.
Dermatology
Maurice L. Kelley, Jr., M.D., Rochester, N. Y.
Gastroenterology
Robert I. Wise, M.D., Philadelphia, Pa.
General Practice
Curtis J. Lund, M.D., Rochester, N. Y.
Gynecology
S. Gilbert Blount, M.D., Denver, Colo.
Internal Medicine
Jerome W. Conn, M.D., Ann Arbor, Mich.
Internal Medicine
Francis Murphey, M.D., Memphis, Tenn.
Neurologic Surgery
Bayard Carter, M.D., Durham, N. C.
Obstetrics
William F. Hughes, M.D., Chicago, Ill.
Ophthalmology
Milton S. Thompson, M.D., San Antonio, Tex.
Orthopedic Surgery
Benjamin Castleman, M.D., Boston, Mass.
Pathology
Harry C. Shirkey, M.D., Birmingham, Ala.
Pediatrics
Richard H. Marshak, M.D., New York, N. Y.
Radiology
Warren H. Cole, M.D., Chicago, Ill.
Surgery
Preston A. Wade, M.D., New York, N. Y.
Surgery
Robert Lich, Jr., M.D., Louisville, Ky.
Urology

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CLASSIFIED

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Volume 50 of The Journal began with the July issue and ended with the December 1963 issue. Volume 51 began with January 1964 and ends with December 1964. The House of Delegates directed that each volume begin with the calendar year in order to correspond with the other activities of the Association.

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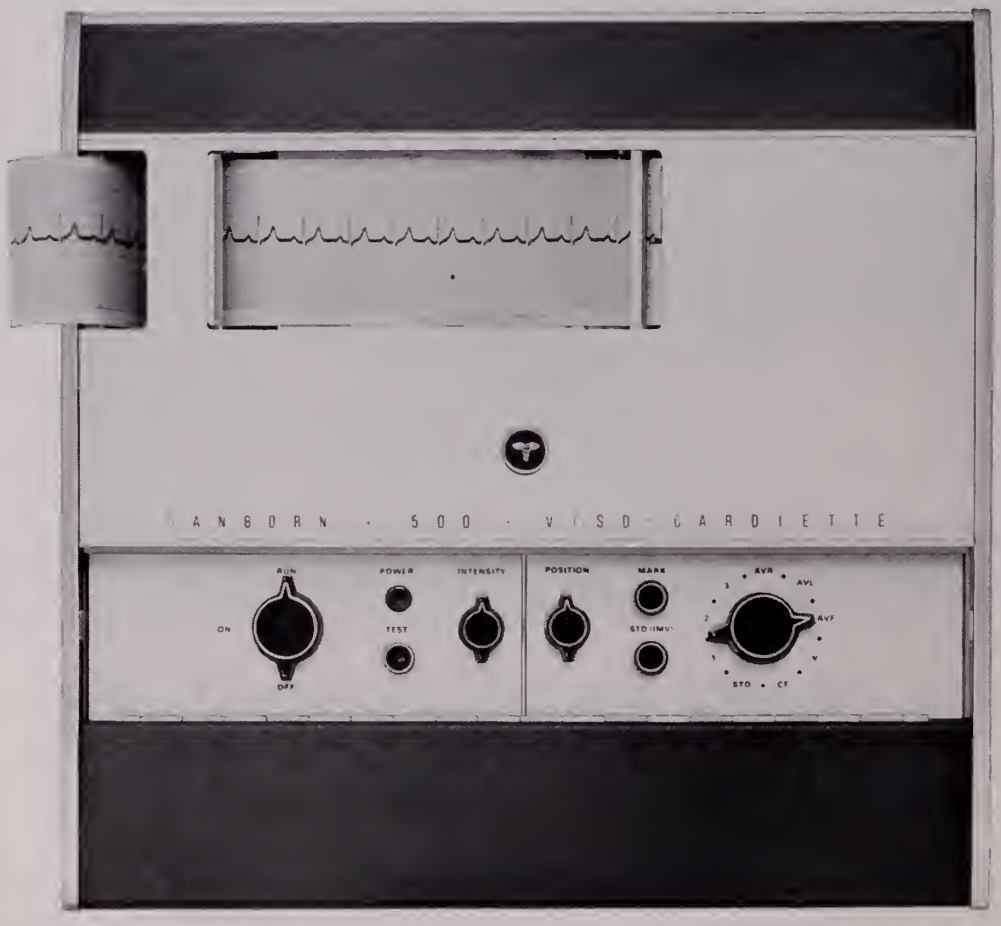


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* AMA Council on Foods and Nutrition: The Regulation of Dietary Fat, *JAMA* 181:411-423 (August 4, 1962).
AMA Council on Foods and Nutrition: Composition of Certain Margarines, *JAMA* 179:719 (March 3, 1962).



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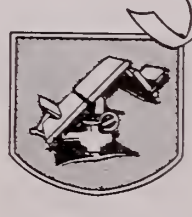
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Samuel M. Day, Jacksonville	Floyd K. Hurt, Jacksonville	Bal Harbour, Apr. 21-25, '65
Florida Specialty Societies			(Specialty Group meetings are scheduled at the time of the annual meeting of the Association)
Allergy Society	Morton L. Hammond, Miami	Woods A. Howard, Lakeland	
Anesthesiologists, Soc. of	Francis M. Coy, Jacksonville	John A. Rusb, Jacksonville	
Chest Pbys., Am. Coll. Fla. Chap.	Minas Joannides Jr., St. P'burg	Franklin G. Norris, Orlando	
Dermatology, Soc. of	Wm. H. Eyster Jr., Daytona Bch.	William W. Bruce, Winter Park	
General Practice, Academy	Geo. W. Edwards II, Orlando	Charles H. Burke, Jacksonville	
Healtb Officers', Soc. of	William R. Stinger, Miami	Joseph W. Lawrence, Ft. Myers	
Internal Medicine	John M. Packard, Pensacola	Lawrence E. Geeslin, J'ville	
Neurosurgical Society	John M. Thompson, St. P'burg	Jack W. Barrett, Miami	
Obst. & Gynec. Society	Sam W. Denham, Jacksonville	Davis H. Vaughan, Clearwater	
Ophth. & Otol. Society	Josepb W. Taylor Jr., Tampa	Bernard M. Barrett, Pensacola	
Orthopedic Society	Theodore Norley, W. Palm Beach	Leon H. Mims Jr., Coral Gables	
Pathologists, Society of	Sanford A. Mullen, Jacksonville	Laudie E. McHenry Jr., Melbourne	
Pediatric Society	George W. Griffin, Orlando	Oliver F. Deen Jr., Tampa	
Phys. Med. & Rehab., Fla. Soc.	Arthur J. Pasacb, Tampa	Geo. A. Cunningham, Delray Bcb.	
Plastic & Reconstr. Surg.	D. Ralpb Millard Jr., Miami	J. M. Hamilton, St. P'burg	
Proctologic Society	Jobn R. Butter, St. P'burg	John J. Cheleden, Daytona Bch.	
Psycbiatric Society	Albert C. Jaslow, Miami	William C. Ruffin Jr., Gainesville	
Radiological Society	Marvin V. McClow, Jacksonville	Andre S. Capi, Ft. Lauderdale	
Surgeons, Am. Coll., Fla. Chap.	Charles Larsen Jr., Lakeland	Harry W. Reinstine Jr., J'ville	
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Surgeons, General, Fla. Assn.	L. Washington Dowlen, Miami	John H. Terry, Jacksonville	
Urological Society	John T. Karaphillis, Clearwater	Robert N. Webster, Tallabassee	
FLORIDA			
Basic Science Exam. Board	P. A. Vestal, Winter Park	T. A. Ashford, Tampa	Miami, June 5, '65
Blood Banks, Association	J. T. Branham, Orlando	Mary Rand, Orlando	Orlando, Apr. 30-May 1-2, '6
Blue Cross of Florida, Inc.	C. Dewitt Miller, Orlando	H. A. Schroder, J'ville	November, 1965
Blue Shield of Florida, Inc.	W. Dean Steward, Orlando	John T. Stage, J'ville	Bal Harbour, Apr. 21-25, '65
Cancer Council	Earl E. Wilkinson, Tallahassee	James E. Fulghum, J'ville	Bal Harbour, Apr. 22, '65
Diabetes Association	James E. Fulgbum, J'ville	Matthew E. Morrow, J'ville	J'ville, Oct. 1, '65
Dental Society, State	Richard C. Chace, Orlando	H. B. Pattishall Jr., J'ville	Hollywood, May 16-19, '65
Heart Association	W. Jape Taylor, Gainesville	T. L. Batchelder, J'ville	Orlando, May 1965
Hospital Association	Samuel Gertner, Miami Beach	L. R. Jordan, Gainesville	November, 1965
Board of Medical Examiners	George H. Garmany, Tallahassee	Leo Grossman, Miami Beach	J'ville, June 26-28, '65
Pharmaceutical Assn., State	Freeman C. Oikle, Miami	R. Q. Richards, Ft. Myers	Bal Harbour, May 16-19, '6
Public Healtb, Association	C. L. Brumback, W. Palm Beach	Miles T. Dean, J'ville	Clearwater, Oct. 2-9, '65
Thoracic Society	A. E. Anderson Jr., J'ville	Mark W. Wolcott, Coral Gables	Miami, Apr. 23-24, '65
Tuberculosis & Res. Dis. Assn.	Harry Schnabel, Ponte Vedra	Mrs. D. Milberger, Gr. Cove Spgs.	J'ville, April 1965
Woman's Auxiliary	Mrs. W. L. Fitzgerald, Miami	Mrs. R. B. Carson, Ft. Lauderdale	Bal Harbour, Apr. 21-25, '65
American Medical Association	Donovan F. Ward, Dubuque, Ia.	F. J. L. Blasingame, Chicago	New York, June 20-24, '65
A.M.A. Clinical Session			Bal Harbour, Nov. 29-Dec. 2, '64



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SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL MEMBERS Associate	Active
Alachua	Thomas M. Brill, Gainesville	Carl E. Van Arnam, Gainesville	2nd. Tues.	16	124
**Bradford, Gilchrist, Union*					
Bay	James A. Poyner, Panama City	Dixon R. McCloy, Panama City	1st Tues.	0	36
Brevard	John M. Langstaff, Melbourne	Daniel L. Donovan, Melbourne	1st Tues.	5	125
Broward	Robert H. Pfeifer, Ft. Lauderdale	Henry D. Perry Jr., Hollywood	4th Tues.	33	370
Charlotte	Roscoe S. Maxwell, Punta Gorda	Arno von Ruckteschell, Punta Gorda	2nd Tues.	1	10
Clay	Thomas L. Glennan, Green Cove Spgs.	Aubrey Y. Covington, Green Cove Spgs.		0	7
Collier	James L. Robinson, Naples	Ethel H. Trygstad, Naples	4th Tues.	0	18
Columbia	Barney E. McRae, Lake City	John T. Wilson, Lake City	3rd Wed.	1	14
**Baker*					
Dade	DeWitt C. Daughtry, Miami	William M. Straight, Miami	1st Tues.	152	1,264
DeSoto-Hardee-Glades	Calvin W. Martin, Arcadia	Harold S. Agnew, Arcadia	1st Tues.	0	16
Duval	A. MacKenzie Manson, Jacksonville	Emmet F. Ferguson Jr., Jacksonville	1st Tues.	39	378
Escambia	Alpheus T. Kennedy, Pensacola	Donald McMahon Jr., Pensacola	2nd Tues.	3	129
Franklin-Gulf	Joseph P. Hendrix, Port St. Joe	Willa Dean Lowery, Apalachicola	Last Wed.	0	6
Gadsden-Liberty	James B. O'Connor, Chattahoochee	Hilliard R. Reddick, Quincy	Quarterly	0	17
Highlands	Vernon G. Watters Jr., Sebring	Helen M. Williams, Avon Park	3rd Mon.	3	20
Hillsborough	Chas. McC. Gray, Tampa	Frank A. Massari, Tampa	1st Tues.	7	310
Indian River	Charles C. Flood, Vero Beach	E. B. Hardee Jr., Vero Beach	2nd Tues.	1	19
Jackson-Calhoun	Grayson C. Snyder, Blountstown	Francis M. Watson, Marianna	Quarterly	0	17
Lake	Louis R. Bowen, Eustis	Frederick C. Hester III, Eustis	1st Mon.	2	40
Lee-Hendry	James C. Carver, Ft. Myers	John J. Krueger, Ft. Myers	3rd Mon.	1	53
Leon-Wakulla-Jefferson	Thomas J. Bixler, Tallahassee	I. Barnett Harrison, Tallahassee	1st Mon.	9	80
Madison	A. Franklin Harrison, Madison	Thomas G. Bouland Jr., Madison	1st Tues.	1	5
Manatee	Willis W. Harris, Bradenton	Robert C. White, Bradenton	2nd Tues.	5	51
Marion	Alexander Goulard Jr., Ocala	West Bitzer, Ocala	3rd Tues.	3	41
**Levy*					
Monroe	Isabel Knowlton, Key West	John L. Ingham, Key West	1st Thurs.	2	20
Nassau	Cecil B. Brewton, Fernandina Beach	John B. Britton, Fernandina Beach	2nd Thurs.	3	8
Okaloosa	Wm. W. Thompson, Ft. Walton Bch.	G. M. Hollingsworth, Ft. Walton Bch.	1st Wed.	3	24
Orange	Miles W. Thomley, Orlando	Duane C. Deen, Orlando	3rd Wed.	36	300
** Osceola*					
Palm Beach	Russell D. D. Hoover, W. Palm Beach	Bernard Kimmel, W. Palm Beach	4th Mon.	33	244
Pasco-Hernando-Citrus	Jorge O. Escamilla, Brooksville	W. Wardlaw Jones, Dade City	2nd Thurs.	3	24
**Sumter*					
Pinellas	C. Gibson Hooten, St. Petersburg	Abbott Y. Wilcox Jr., St. Petersburg	1st Mon.	84	347
Polk	Arthur J. Moseley Jr., Lakeland	Wayne O. Montgomery, Lakeland	2nd Wed.	24	158
Putnam	Claude M. Knight, Palatka	James R. Sayers, Palatka	2nd Tues.	0	16
St. Johns	Frank J. LaRosa, St. Augustine	Kenneth J. Farrow, St. Augustine	3rd Tues.	0	19
St. Lucie-Okeechobee-Martin	Maltby F. Watkins, Ft. Pierce	George Theodorou, Ft. Pierce	3rd Thurs.	0	47
Santa Rosa	Claude J. Barnes, Milton	John C. Holley Jr., Milton		1	14
Sarasota	Harry O. Specht, Sarasota	Thomas F. Scott, Sarasota	2nd Tues.	19	107
Seminole	George H. Starke, Sanford	Charles W. Hardwick, Sanford	2nd Tues.	0	25
Suwannee-Hamilton Lafayette	Wilton R. Kane, Live Oak	Hugo F. Sotolongo, Live Oak	1st Sat.	0	7
Taylor	T. Conrad Williams Jr., Perry	John A. Dyal Jr., Perry	Last Fri.	0	6
**Dixie*					
Volusia	Hugh Crawford, Daytona Beach	Michael R. Blais, Daytona Beach	2nd Tues.	5	114
**Flagler*					
Walton	Evans L. Huggins, DeFuniak Springs	McKinley Cheshire, Jr. DeFuniak Springs	3rd Tues.	0	7
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Indications: Valium (diazepam) is of use in dealing with anxiety reactions stemming from stressful circumstances or whenever somatic complaints are concomitants of emotional factors. It is useful in psychoneurotic states manifested by anxiety, tension, fear and fatigue.

Valium (diazepam) may also be useful in acute agitation due to alcohol withdrawal.

Valium (diazepam) may be of use to alleviate muscle spasm associated with cerebral palsy and athetosis.

Dosage and administration	*Usual daily dose*
Mild to moderate psychoneurotic reactions: Manifested by anxiety-tension alone or with depressive symptomatology, agitation, restlessness, psychophysiological disturbances	2 mg to 5 mg, 2 or 3 times daily
Severe psychoneurotic reactions: Where severe anxiety, fear, agitation, aggression or hostility exist alone or with depressive symptoms	5 mg to 10 mg, 3 or 4 times daily
Alcoholism: As an aid in symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis	10 mg, 3 or 4 times during the first 24 hours; reducing to 5 mg, 3 or 4 times daily as needed
Muscle spasm associated with cerebral palsy or athetosis	2 mg to 10 mg, 3 or 4 times daily

Contraindications: Valium (diazepam) is contraindicated in infants, patients with a history of convulsive disorders or patients with a history of glaucoma.

Warning: Valium (diazepam) is not of value in the treatment of psychotic patients, and for this reason should not be employed in lieu of appropriate treatment.

Precautions: In elderly or debilitated patients, it is important to limit the dosage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, to be increased gradually as needed and tolerated). As is true of all CNS-acting drugs, until the correct maintenance dosage is established, patients receiving Valium (diazepam) should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving an automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam)—particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

Since Valium (diazepam) has a central nervous system depressant effect, patients should be advised against the simultaneous ingestion of alcohol and other central nervous system depressant drugs during Valium (diazepam) therapy. Safe use of Valium (diazepam) during pregnancy has not been established. The usual precautions are indicated when Valium (diazepam) is used in the treatment of anxiety states where there is any evidence of impending depression; particularly the recognition that suicidal tendencies may be present and protective measures may be necessary. The usual precautions in treating patients with impaired renal or hepatic function should be observed.

Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (*e.g.*, convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

Paradoxical reactions, such as excitement, depression, stimulation, sleep disturbances, acute hyperexcited states and hallucinations have been reported. Other side effects noted have been blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash.

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